VALLEY YOUTH HOUSE
PRIVACY & SECURITY OF PROTECTED HEALTH AND PERSONAL INFORMATION PRACTICE STATEMENT
(REVISED 1/9/07)

These practice statements are intended to provide standards for the management of workplace issues that cross all entities of Valley Youth House and all agency Protected Health and Personal Information. In general, they cover who has the right to access personally identifiable information and the processing of protected health and personal information. These standards limit the non-consensual use and release of private health and personal information, give clients rights to access their records and to know who else has accessed them, restricts most disclosure of health and personal information to the minimum needed for the intended purpose, establishes sanctions for improper use or disclosure and requirements for access to records by researchers and others.

The information in this document applies to all Valley Youth House staff, students, volunteers and any other contractors or agents granted access to Protected Health and Personal Information (PHPI). Information covering other services provided by Valley Youth House is not covered in this document.

I. HIPAA and HUD-SHHF Compliance Dates

- HIPPAA: VYH will comply with the applicable requirements no later than April 13, 2003 will.
- HUD-SHHF: VYH will comply with the standards for Homeless Management Information Systems issued by the Department of Housing and Urban Development no later than July 30, 2004. Reference: 69 Federal Register 45888 (July 30, 2004)
- VYH will keep records and submit compliance reports as required by the U.S. Secretary of the Department of Health and Human Services.
- VYH will cooperate with the complaint investigations and compliance reviews undertaken by the U.S. Secretary of the Department of Health and Human Services.
- VYH will permit the U.S. Secretary of the Department of Health and Human Services access to facilities, books, records, accounts and other sources of information, including PHPI, which are pertinent to ascertaining compliance.
- For purposes of cooperation with DHHS investigations, VYH will attempt to obtain information in the exclusive possession of any other agency, institution, or person. If the other sources of information fail or refuse to furnish the information, VYH will document and certify what efforts it has made to obtain the information.

Reference: § 160.310, 164.534 Health Insurance Portability and Accountability Act of 1996

II. RECORD KEEPING

The VYH is committed to achieving excellence in retaining documentation of all items related to information security and privacy. It is our intention to comply with state, and federal laws. The organization will maintain accuracy and completeness of such documents in a secure and confidential manner for a specified time frame as defined by

state and federal regulations or guidelines. *Please refer to the Pennsylvania Department of Public Welfare Manual governing records retention in State Agencies. All documents noted below will be kept AT LEAST for the 6 years required by HIPAA, but in many instances must be retained for longer periods to comply with State retention periods.*

Records kept for the Privacy and Security of Protected Health and Personal Information may include, but are not limited to:

- All policies and procedures
- Authorization forms (blank and signed)
- Notice of Privacy Practices (all versions)
- Business associate contracts
- Requests for inspection/copying, including denials
- Requests for amendment and the responses to those requests
- Requests for Accounting of Disclosure of PHPI, and copy of account log given to client
- Workforce training logs
- Complaints received and resolution of same
- Requests for restrictions/confidential communications PHPI, and agreement/denial
- Privacy Coordinator's job description
- Billing/Payment Records
- Client Acknowledgment of Privacy Notice

Reference: §164.530 (j) The Health Insurance Portability and Accountability Act of 1996

III. PRIVACY DEFINITIONS

The following are terms used in VYH's privacy policies:

Accounting of Disclosures: A listing of all disclosures made by VYH of a client's PHPI in the six years prior to the date on which the accounting is requested by the client. Disclosures exempted from this listing are those made:
• Pursuant to the individual's own authorization.
• To carry out treatment, payment, or operations.
• To correctional institutions or law enforcement officials.
• That occurred prior to the compliance date.

Authorization: A release required in writing by the client (or his/her representative) for all other uses and disclosures of PHPI not included in treatment, payment, or operations such as when a client requests his/her records for use outside of VYH.

Business Associates are:
• Persons who act on behalf of VYH in performing a function or activity involving the use or disclosure of individually identifiable health and personal information, including, but not limited to, claims processing or administration, analysis, processing or administration of data, utilization review, quality assurance, billing, practice management.
• Persons who provide, other than in the capacity of a member of the workforce of VYH, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for VYH.

Client Tracking System (CTS): Valley Youth House's computerized management information system.

De-identification: means health or personal information that does not identify an individual. If there is no reasonable basis to believe that the information can be used to re-identify an individual, the information is not individually identifiable health or personal information.

Designated record set: A group of records maintained by or for VYH, which are the clinical records and billing records about clients used, in whole or in part, to make decisions about clients.

Disclosure: means with respect to individually identifiable information, the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Fundraising: is defined as the organized activity of raising funds for an organizational cause.

Operations: means any of the following activities:
• Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines; protocol development, case management and care coordination, contacting of providers and clients with information about treatment alternatives, and related functions that do not include treatment;
• Reviewing the competence or qualifications of mental health care professionals, evaluating practitioner and provider performance, conducting training programs in which students, trainees, or practitioners in areas of social services learn under supervision to practice or improve their skills as clinician or case manager, accreditation, certification, licensing, or credentialing activities;
• Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
• Business planning and development
• Business management and general administrative activities

Health Insurance Portability and Accountability Act (HIPAA): A federal law, the intent of which is to protect the privacy and security of client health information that is created or maintained by care providers.

Homeless Management Information System (HMIS): is a computerized data collection application that facilitates the collection of information on homeless individuals and families using residential or other homeless assistance services and stores that data in an electronic format.

Individually Identifiable Health Information (IIHI): is a subset of information including demographic and financial information collected from an individual, and:
• Is created or received by a mental health provider,
• Relates to the past, present, or future mental health condition of an individual; the provision of care to an individual; or the past, present, or future payment for the provision of care to an individual which:

- Identifies the individual
- Or causes reasonable belief that such information can be used to identify the client.

Minimum Necessary: The amount of PHPI necessary to accomplish the intended purpose of the use or disclosure. All practical and technological limitations will be considered.

Notice of Privacy Practices: A document that provides an individual notice of the uses and disclosures of PHPI, which may be made by VYH, and of the client's rights and our legal duties with respect to PHPI. An acknowledgment of the Privacy Notice by the client is obtained in writing.

Protected Health Information (PHI): any type of individually identifiable health information, whether electronically maintained, electronically transmitted, or in any other format (i.e. discussed orally, on paper or other media, photographed or otherwise duplicated).

Protected Personal Information (PPI): any type of individually identifiable personal information we maintain about a client that:

- Allows identification of an individual directly or indirectly
- Can be manipulated by a reasonably foreseeable method to identify a specific individual, **or**
- Can be linked with other available information to identify a specific client.

Protected Health and Personal Information (PHPI): acronym used to identify applicability of statements to both Protected Health Information (PHI) and Protected Personal Information (PPI).

Record: means any item, collection, or grouping of information that includes PHPI, and is maintained, collected, used, or disseminated by or for VYH.

Required by law: means a mandate contained in law that compels VYH to make a use or disclosure of PHPI and that is enforceable in a court of law. *Required by law* includes, but is not limited to:

• Court orders and court-ordered warrants;
• Subpoenas or summons issued by a court, grand jury, a governmental, or an administrative body authorized to require the production of information;
• A civil or an authorized investigative demand;
• Medicare conditions of participation with respect to mental health care providers participating in the program; and
• Statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

Research: means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Sanctions: A consequence given to members of VYH's workforce who fail to comply with VYH privacy practices and procedures.

Trading partner agreement: means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement.

Treatment: The provision, coordination, or management of care and related services by one or more mental health provider(s) or supportive housing provider(s), including the coordination or management of services by a provider with a third party; consultation between other care or supportive housing providers relating to a client; or the referral of a client for services from one provider to another.

Use: The sharing, employment, application, utilization, examination, or analysis of such information with respect to individually identifiable health and/or personal information, within VYH.

Workforce: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for VYH, is under the direct control of VYH, whether or not they are paid by VYH.

Reference: §160.103 and § 164.501 The Health Insurance Portability and Accountability of 1996

IV. TRAINING OF WORKFORCE

A. Education and Training is provided to individuals who have access to protected health and personal information, and other sensitive and/or confidential information.
B. Security and Privacy training focuses on:
    1. Appropriate access, use and disclosure of PHPI
    2. Responsibility regarding confidentiality, security and protection of health and personal information
    3. Organizational consequences when standards are breached.
C. The Training Coordinator develops training content for both Security and Privacy.
D. Initial institutional training for all required staff will occur before the identified compliance date. (Privacy - April 14, 2003, Security – September 22, 2005)
E. New employees who are required to complete Security and Privacy training will do so during standard orientation period as part of their competency based training.
F. When significant changes in policy and/or procedure occur, the affected workforce will be trained as soon as possible after the changes.
G. Training is documented in written or electronic form and retained for at least six years.
H. All staff noted in the scope statement of this policy sign a confidentiality statement, upon hire and whenever a significant change is made to the policy thereafter.

Reference: §164.530 (b) Health Insurance Portability and Accountability Act of 1996

V. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY WHISTLEBLOWERS AND WORKFORCE MEMBER CRIME VICTIMS

As a general rule, VYH personnel may not disseminate PHPI without a valid authorization, or as authorized by law. However, PHPI may be used or disclosed by whistleblower or workforce member crime victims as defined below.

1. WHISTLEBLOWERS

Whistleblowers may be workforce members or business associates. PHPI may be disclosed:

a. If the workforce member or business associate believes in good faith that VYH has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by VYH potentially endangers one or more clients, workers, or the public; and
b. If the disclosure is to an oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of VYH or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct.

2. VICTIMS OF A CRIME

a. A member of the VYH workforce who is the victim of a crime may disclose PHPI to a law enforcement official, provided that:

1. The PHPI disclosed is about the suspected perpetrator of the crime; and

2. The PHPI disclosed is limited to the following:

- name and address;
- date and place of birth;
- date and time of death, if applicable; and
- a description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or mustache), scars, and tattoos.

Reference: § 164.502 (j) Health Insurance Portability and Accountability Act of 1996

VI. SANCTIONS FOR BEACHES OF PRIVACY & SECURITY OF PHPI AND VYH'S DUTY TO MITIGATE SUCH BREACHES

A. VYH's policies regarding privacy and security of protected health and personal information reflects its commitment to protecting the confidentiality of client's records, accounts, clinical and personal information from management information systems, confidential conversations, and any other sensitive material as a result of doing business. To ensure compliance with these practices and to ensure that the disciplinary actions taken as a result of breach of client confidentiality are applied consistently, VYH will follow the disciplinary process outlined in the Personnel Policy. This policy will be used for mitigating to a practical extent, any harmful or injurious effect of unauthorized uses or disclosures of all forms of protected health and personal information (paper, electronic, or oral). To this end, oversight, detection, and reporting mechanisms have been established to know when violations occur. Additionally, processes are in place to limit the damage incurred.

B. DEFINITIONS: A breach of confidentiality is defined as violating the provisions of VYH's Confidentiality Policy or the Privacy and Security of Protected Health and Personal Information Practices. As a mental health and HUD-supportive housing provider, VYH is entrusted with demographic, financial and clinical information regarding our clients. The designated client record is highly confidential and must be treated with great respect and care by any individual with access to this information. Any breach in confidentiality by workforce

members is subject to formal discipline up to and including termination as set forth in the Personnel Policy.

DISCIPLINARY PROCESS**:** The following process must be followed when a workforce member breaches, or is suspected of breaching, confidentiality:

1. Initial Reporting

a. Electronic/computer systems affected: Notify the Computer System Administrator about any significant error, or suspicion of viruses. Be sure to document any messages displayed on the system or a brief explanation of the problem that is occurring. Despite existing network system security and protections, security breaches are possible and must be reported.

b. Breaches by persons or behaviors resulting in breaches of confidentiality: The individual who observes or is aware of some type of improper disclosure of information is required to report it in one of the following ways:

• Immediate supervisor
• Director or Supervisor of the area in which the individual works
• Privacy Coordinator

c. The original contact person notified under "Section b" must notify the Computer System Administrator for breaches technological in nature or the Privacy Coordinator for breaches behavioral in nature. All reports will be handled confidentially but such confidentiality cannot be guaranteed. Information about incidents is considered to be confidential and confined internally. Some circumstances may dictate notification to staff and third parties, but this is at the discretion of the President and CEO who may direct such other persons conduct the inquiry, as he deems appropriate.

d. Reporting a breach in bad faith or for malicious reasons may be interpreted as a misuse of the reporting mechanism(s) and may result in disciplinary action.

2. Investigations of Reported Breaches

a. Information pertaining to investigations of breaches will only be shared with those who have an absolute need to know. The investigator(s) will conduct the necessary and appropriate investigation commensurate with the level of breach and the specific facts. This investigation may include, but is not limited to, interviewing the individual accused of the breach, interviewing other individuals, and reviewing pertinent documentation.

b. Existing VYH procedures for disciplinary action shall be utilized.

3. Examples of breaches of confidentiality; *this is not an all-inclusive list*.

• Individuals discussing client information in any public area where those who have no need to know the information can overhear.
• Individual leaves a copy of client information in a public area.
• Individual leaves a computer unattended in an accessible area with CTS and/or HMIS information unsecured.
• Failure to log off computer terminal.
• Sharing or exposing passwords.
• An individual accesses and/or reviews birth dates, addresses of friends or relatives, or requests another individual to do so.
• An individual accesses and/or reviews the record of a client out of concern or curiosity, or requests another individual to do so.
• An individual accesses and/or reviews a client record to use information in a personal relationship.
• An individual accesses and/or reviews the record of a public personality out of concern or curiosity, or requests another individual to do so.

• An individual accesses and/or reviews the client record of a public personality for the intent of giving or selling information to the media.
• An individual accesses and/or reviews confidential information of another employee that is also a client.
• An individual accesses and/or reviews confidential information that may bring harm to the organization or individuals associated with it.

4. Duty to Mitigate Valid Breaches:

a. The organization has a duty to take reasonable corrective steps when notified of breaches of privacy and or security of PHPI by its workforce members. This sanction practice applied fairly and consistently is one of the actions VYH will take in the event of a breach by a workforce member.

b. The organization also has a duty to take reasonable corrective steps when notified of breaches of contract terms by business associates. While VYH is not required to monitor the activity of our business associates, we will address problems, as we become aware of them and request that our associates remedy their behavior. VYH reserves the right to terminate contracts if it becomes clear that the business partner cannot be relied upon to maintain the privacy of information we provided to them.

c. The President, Executive Vice President, and Senior Vice Presidents shall be prepared to contact law enforcement, regulatory, accreditation, and licensure bodies as necessary in order to properly mitigate policy violations.

5. Documentation and Tracking of Breaches:

a. An analysis of reported privacy breaches by persons or behaviors is prepared by the Privacy Coordinator twice per year and reported to the President and the Board of Directors.

b. All information documenting the inquiry of the incident or violation will be retained for a period of six years.

Reference: § 164.530 (e) Health Insurance Portability and Accountability Act of 1996

VII. DISPOSAL OF PROTECTED HEALTH AND PERSONAL INFORMATION

VYH has a duty to protect the confidentiality and integrity of confidential information as required by law, professional ethics, and accreditation requirements. This policy is to define the guidelines and procedures that must be followed when disposing of information containing PHPI.

Destruction of Paper Copies and Original Documents (Day-to-Day Disposal)

Any printed material (e.g., faxes, printed emails, informal notes about clients) containing PHPI must not be discarded in trash bins, unsecured recycle bins or other publicly accessible locations. Instead this information must be personally shredded or placed in shredder box in a designated secure area in each office.

• The user may elect to use either shredding or secured shredder boxes, as long as the destruction is in accordance with this policy. It is the individual's responsibility to ensure that the document has been secured or destroyed. It is the supervisor's responsibility to ensure that their employees are adhering to the practice.
• After documents have reached their retention period according to the Commonwealth of Pennsylvania, all PHPI must be securely destroyed.

Electronic Media
Secure methods will be used to dispose of electronic data and output. The Computer System Administrator is responsible for the removal of all VYH information, including PHPI, resident on any electronic storage media/device prior to removal or sale of such devices.

Information maintained on a disc should not be removed from the office and should be maintained in a secure location in the office. When the disc with the information is no longer of use it should be broken to ensure the destruction of the PHPI.

Portable devices such as "personal digital assistance" (PDA) devices should be password protected, and there should be no PHPI stored on them. If used to enter PHPI, this should be routinely downloaded and the information deleted from the portable device.

Documentation of PHI Disposal
To ensure that it is in fact performed VYH personnel or a bonded destruction service must carry out the destruction of PHI.
• If VYH personnel undertake the destruction of the records, the VYH personnel must use the VYH Records Destruction form. Records cannot be destroyed without the approval of the Program Director.
• If a bonded shredding company is utilized for the final destruction of the records, the company must provide VYH with a manifest of destruction that contains the following information: 1) Date of destruction, 2) Method of destruction, 3) Description of the disposed records, 4) Inclusive dates covered, 5) A statement that the records have been destroyed in the normal course of business, 6) The signatures of the individuals supervising and witnessing the destruction. The Executive Vice President and the Senior Vice Presidents will maintain a record of the destruction of the documents permanently.

All supervisors are responsible for enforcing this policy. Individuals who violate this policy will be subject to the disciplinary process as outlined in the HIPAA sanctions policy.
Reference: § 164.514 Health Insurance Portability and Accountability Act of 1996

VIII. CLIENTS' RIGHTS TO PRIVACY OF PROTECTED HEALTH AND PERSONAL INFORMATION; RIGHTS OF INDIVIDUALS
The Valley Youth House recognizes the importance of protecting the privacy of our clients and the health and personal information they entrust to us. We respect the rights of our clients with regard to protected health and personal information and will take appropriate precautions to maintain its confidentiality.
A. **The right to be informed**. VYH informs clients of the ways protected health and personal information is used and disclosed by the organization and their individual rights with respect to that information. This "Notice of Privacy Practices" is given to all clients, and is obtainable on our website.
B. **The right of an individual,** including an individual who has agreed to receive "The Notice of Privacy Practices" electronically, to obtain a paper copy of the notice from VYH upon request. (See: Notice of Privacy Practices)
C. **The right to request restrictions** on certain uses and disclosures of protected health and personal information, although we are not required to agree to a requested restriction. Restrictions cannot apply to public health/oversight information or other types of information that do not require client authorization for release. Requested restrictions will be granted/denied based on existing VYH policies.

D. **The right to receive confidential communications**. Clients may request that we communicate with them about matters in a certain way or location (e.g., only at work or only by mail). We will accommodate all reasonable requests.
E. **The right to inspect and copy protected health and personal information.** Request must be made in writing. Any type of information that may be withheld from the client in accordance with the law (such as the origins of a child abuse allegation) shall be defined in VYH program manuals.
F. **The right to amend protected health and personal information**. Request must be made in writing. Information may not be deleted, but amendments can be made and included in record.
G. **The right to request an accounting of disclosures of protected health information**. Request must be made in writing. We are not obligated to list all disclosures made, or to duplicate the exact information contained in each disclosure.
Reference: § 164.510,164.512,164.520,164.522.164.524,164.526,164.528

IX. PRIVACY PRACTICES: VYH NOTICE TO CLIENTS PRACTICE STATEMENT

1. Content: The Notice contains:
• A description of uses and disclosures that we are permitted to make for treatment, payment and oversight.
• A description of uses and disclosure made without client authorization.
• Which uses are required by law and which are permitted by law.
• A description of other uses and disclosures for which the agency will seek client authorization.
• An explanation of our duties under this law.
• An explanation of the client's right to revoke authorization.
• The client's right to request restrictions, to which the entity may or may not be, obligated to accept.
• The client's right to confidential communications.
• The client's right to inspect and/or request copies of the information in the record and request amendments.
• The client's right to an accounting of disclosures made of his/her information.
• All procedures for how clients exercise these rights.
• A contact name (or office) and telephone number to contact us for complaints.
• A statement that the individual will not be retaliated against for complaints.
• An explanation that the client may complain to the Secretary of DHHS.
• The date of the version of the Notice.

2. Review, Dissemination and Retention of the Notice:
By disseminating a Notice of Privacy Practices, VYH is accountable to its clients for uses and disclosures of protected health and personal information.
a) The Privacy Coordinator reviews the Notice on an annual basis. If any changes or revisions are made, VYH will again disseminate that new information to all clients/staff.
b) The Notice is reviewed with all staff members upon hire and again whenever material change in the Notice is made.
c) The Notice is disseminated:
• To all past clients at the first instance of service delivery following the compliance date or revision date
• To all new clients upon first delivery of service
• By posting the Notice prominently for clients and visitors to see

• By posting the Notice on our website
• To any client requesting the Notice electronically
e) The Privacy Coordinator retains the Privacy Notice and policies and procedures related to the Notice for six years from the date of its creation or the date when it was last in effect, whichever is later.

3. Documentation of Client Acknowledgment:
VYH is obligated to document compliance with the Notice requirements:
a) By asking each client to sign an acknowledgement of receipt of the Privacy Notice at the time of his/her first visit for service after compliance date (April 14, 2003); this acknowledgement is either included on the basic consent to treatment form or on a separate form.
b) By entering into Client's record and CTS the date of signature of client's acknowledgement of receipt or that client refused to sign the acknowledgement and date.
c) By maintaining a copy of the signed acknowledgement in client's record.
Reference: § 164.520 Health Insurance Portability and Accountability Act of 1996

X. PERMISSION TO TREAT/ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE RECORDS/AUTHORIZATION TO ENTER PERSONAL INFORMATION INTO THE HMIS DATABASE/ACKNOWLEDGEMENT OF RECEIPT

A. VYH will require clients to sign a Consent to Treatment form, Authorization to Release Medical Information, and/or Authorization to Enter Personal Information into the HMIS Database as applicable to the client's VYH program involvement. VYH makes a good faith effort to obtain written acknowledgment of the client's receipt of the Notice of Privacy Practices at the time of first service delivery after April 14, 2003 and any revision date of VYH's notice.

B. Signature dates will be noted in the CTS database and form will be retained in the client's record.

C. Dates will be monitored and lack of signature will require follow-up with the client for completion.

D. The signing of the acknowledgement of receipt of the Privacy Notice is not a requirement for treatment. VYH documents the individual's refusal to sign the form. The refusal is documented in the Progress note section of the CTS as well as on the sign off sheet.
Reference: §164.520 Health Insurance Portability and Accountability Act of 1996

XI. CLIENT RIGHT TO REQUEST RESTRICTIONS ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. VYH must permit an individual to request restrictions on the use or disclosure of PHI to carry out treatment, payment, or oversight.

B. VYH is not required to agree to a restriction. Security procedures, confidentiality policies, and all restrictions otherwise required under HIPAA protect our clients' privacy. However, VYH will accept the following restrictions.

1. For Payment
    a. Client's decision not to use insurance or other payor and be considered "self pay."
    b. Client's decision to restrict PHI for payment of bill cannot be accommodated and thus client will be considered "self pay".

c. Client's refusal to authorize release of medical information to health plan and be considered "self pay".
d. These decisions are made at the time of referral and documented in the CTS.

C. VYH may terminate its agreement to a restriction if:

1. the individual agrees to or requests the termination in writing;
2. the individual orally agrees to the termination and the oral agreement is documented; or
3. VYH informs the individual it is terminating its agreement to a restriction and the termination is effective with respect to protected health information created or received after the individual is informed.

D. VYH will document the restriction and termination of the restriction should it occur.

XII. CLIENT RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

To allow clients to request to receive communications of protected health information from VYH by alternate means or at alternate sites.

1. Clients may request to receive correspondence, (including billing statements), at an address other than their home address.
2. Clients may request to receive telephone calls at a number other than their home number.
3. VYH staff may not require an explanation for the client's request.
4. If the client so requests, one alternate location and/or telephone number will be added to the CTS database.
5. Client will be notified by employee entering alternate information that address and/or telephone number will be used for ALL communications between VYH and client.
6. Alternate address and/or telephone number will remain in place until changed by client.
   a. Only client or legal representative may change these restrictions
      1. Changes must be made in writing
      2. Proof of legal representation must be supplied with request

Reference: §164.522 (b) Health Insurance Portability and Accountability Act of 1996

XIII. AUTHORIZATION FOR RELEASE OF INFORMATION

To ensure that release of a client's protected health and personal information is in compliance with privacy rules governing such release. VYH may not use or disclose PHPI without a valid authorization unless such use and disclosure is otherwise permitted or required under the privacy standard or as required by law.

I. Legal Authorizations

A. A legal authorization to release PHPI must be written in plain language and signed by the client or his/her legal representative in order for health and/or personal information to be released. Use or disclosure to authorized individuals/agencies must be consistent with the authorization.

B. A valid authorization must contain the following core elements/information.

- Client's full name
- The name of person or class of persons authorized to make the use or disclosure of PHPI
- Description of the information to be used or disclosed (i.e. specific date of service, etc.)

- Identification of person/agency to whom covered entity is authorized to make the requested use or disclosure (i.e. name, address)
- Description of the purpose for the use or disclosure
- The authorization's expiration date or expiration event that relates to the individual or to the purpose or use of the requested disclosure and no longer protected
- A statement of the client's right to revoke the authorization in writing and how this can be done
- A statement that information used/disclosed under the authorization may be subject to re-disclosure by the recipient
- The signature of the client's or client's personal representative and date of signature
- In addition, it is desirable to have the client's date of birth and address to further correctly identify the client
- A statement that treatment, payment, enrollment and eligibility for benefits cannot be conditioned on whether the individual signs the authorization.

II. Invalid/Defective Authorizations

A. An authorization to use/disclose PHPI is not valid if any of the following circumstances are present:

- The expiration date has passed or the expiration event is known by the VYH to have occurred
- The authorization has not been filled out completely with respect to the required core elements
- The authorization is known to have been revoked in writing
- The authorization is a prohibited type of combined authorization
- Any material information in the authorization is known by the VYH to be false

B. Defective authorizations will be returned to the requestor with an explanation as to why the authorization will not be honored.

III. Revocation of Authorization

A. VYH shall provide a means by which a client may revoke their authorization for release of PHPI.

B. A client has the right to revoke an authorization at any time by means of a written revocation, except to the extent that the VYH has already used or released information while the authorization was still valid. Written revocation must be to the Program Director. VYH may not be able to prevent mailings or use of that information that was disclosed prior to the revocation.

C. Upon receipt of the request to revoke authorization, VYH will stop the processing of information for use or disclosure to the greatest extent practical (with the exception of information for treatment, or payment). VYH shall not be required to call back any information previously released under the valid authorization.

IV. Documentation of Authorization

A. VYH will document and retain the original or an electronic version of all authorizations for release of PHPI on file

B. VYH will keep all revoked authorizations on file along with documentation of any action taken based on the revocation of authorization.

C. A copy of the signed authorization must be given to the client.

V. Combined Authorizations

A. Authorizations may not be combined with any other documents to create a compound authorization except in the following circumstances:

1. An authorization for the use or disclosure of PHPI for a research study may be combined with any other type of written permission for the same research study.

2. The authorization for use or disclosure of psychotherapy notes may only be combined with another authorization for use or disclosure of psychotherapy notes.

3. An authorization, other than authorization for use or disclosure of psychotherapy notes, may be combined with any other such authorization, except when the VYH has conditioned the provisions of treatment, payment, enrollment in a health plan or eligibility for benefits on the provision of one of the authorizations.

VI. Special Rules Regarding Psychotherapy Notes

A. Defined as notes recorded (in any medium) by a provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

B. VYH must obtain an authorization for any use or disclosure of psychotherapy notes, with two exceptions:

1. To carry out treatment, payment, or oversight.

- By the originator of the psychotherapy notes for treatment (use only)
- By VYH in its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve counseling skills (use or disclosure)
- Or by VYH to defend itself in legal action or other proceeding brought by the individual (use or disclosure)

2. A use or disclosure that is

- Required by law
- Permitted disclosures to health oversight agencies with respect to the oversight of the originator of the psychotherapy notes
- Permitted uses and disclosures necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public

C. Pennsylvania's mental health confidentiality laws must still be met even if a HIPAA exception applies. If either HIPAA or Pennsylvania law does not permit disclosure, disclosure should not be made.

VII. Previously Obtained Authorizations

A. Previously obtained, valid consents (i.e., consents, authorizations, or other legal permissions) obtained prior to April 14, 2003 may be used by VYH under the following conditions:

1. The previously obtained consent is valid only for PHI that is created or received by VYH prior to April 14, 2003;

2. The prior consent specifically permits such use or disclosure; and

3. There is no agreed-to restriction on the use or disclosure.

VIII. Prohibition on conditioning authorizations**:**

A. VYH may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on the provision of an authorization, except:

1. VYH may condition the provision of healthcare that is solely for the purpose of creating PHI for disclosure to a third party on acquisition of an authorization to allow such disclosure

PROCEDURE:

I. Signatures on Authorizations

A. An individual is required to sign a valid authorization for the release of his/her PHPI, except when that information is used for treatment, payment or oversight. Circumstances when authorization is required, include but are not limited to:

1. When the individual has initiated the authorization because he/she wants the VYH to disclose PHPI to a third party

2. For disclosure to a health plan or provider for the purpose of making eligibility or enrollment determinations prior to the individual's enrollment in the plan

3. To enter personal information into the HMIS Database.

B. Authorizations must be signed by:

1. The individual whose PHPI is to be released.

2. If the client is deceased, authorization to use or disclose PHPI must be signed by the executor or administrator of the deceased's estate. If an executor of the estate does not exist, the next of kin may sign the authorization to release PHPI (parent, spouse, brother, sister, etc.) If no family can be located, and the client did not designate an individual to serve as conservator and did not execute a durable power of attorney while competent, probate court action is necessary.

3. If the client is a minor age under 18, the client and the parent or legal guardian must sign the authorization for use or disclosure of PHPI. If the guardian is not the parent, legal guardianship is required.

4. Records of minors involving venereal disease, drug abuse, or pregnancy/contraception require the minor's authorization only.

5. If the client is between 0-18 and is in the custody of the State, required authorization from the Department of Children and Youth Services and a court certificate of removal from parents is required. If custody is retained by the parents, they are the only individuals who can authorize use or disclosure of the records

6. A stepparent may not authorize the release for minor's records unless the child was adopted. If the child was adopted by the stepparent, proof is required.

7. If a minor is living in a foster home, the foster parent is not necessarily the legal guardian.

8. In the case of divorce, either parent may authorize release of the child's records. If the parent has lost their parental rights, they are not entitled to authorize use or disclosure of PHPI.

9. Authorization to release PHPI for HIV/AIDS must be signed by the "protected individual."

Reference: §164.508 Health Insurance Portability & Accountability Act of 1996

XIV. CLIENT RIGHT TO INSPECT, COPY, AND AMEND THEIR RECORD

To allow clients, or their authorized representatives, the right to:

• Request to review records of their health and/or personal information as outlined in the designated record set (defined as the client's record & billing records maintained by or for the VYH to make decisions about these individuals)

• Request copies of their health and/or personal information in their record or billing records

• Request that an amendment be made to their record or billing records

The VYH is committed to safeguarding PHPI in order to fulfill its mission to clients and to operate in a manner that is consistent with applicable federal and state laws and regulations. The original client's treatment/billing record is the property of the facility and may not be removed from the facility except by court order. This policy will ensure the client's right to access for review, obtain copies of, and/or amend his/her PHPI, when necessary.

I. INSPECTION AND COPYING OF RECORDS– Clients and/or their legal representatives have the right to review their treatment/billing record information upon request. The request to do so must be in writing. Client representatives have the right to act on the behalf of the client when this is a court appointed status, or when they have the expressed authorization of the client should the client not be able to act on their own behalf.

VYH must act upon a client's request to access their record information within (thirty) 30 days by either supplying the information or sending written notification of denial.

A. Clients or their representatives requesting review and/or copies should be encouraged to wait until discharge and, when possible, until the record has been completed and proper authorization for the review has been obtained. All reviews to be performed post -discharge will be handled under the supervision of the Program Director or his/her designee. Post discharge client review of psychiatric records is subject to the psychiatrist approval.

B. Clients insisting on reviewing their record during the current episode of care may be allowed to do so after the Program Director or designee has been notified of the request and approves. Reviews done during the current episode of care must take place under the supervision of one of the following: the mental health professional, case manager, Supervisor or the Program Director (or a designee). The client is required to complete a proper authorization.

C. Documentation must be included within the record when the client reviews his/her information with specific reference to what was reviewed and/or copied for the client.

D. Only VYH staff is authorized to make copies of a client's record. Clients requesting copies of their record for their own personal use will be charged a fee. Clients will not be charged a fee when the information is for use by another provider. Fees for copies requested by attorneys, insurance companies and other such third parties will be directly billed to the requestor. **It is recommended that copies only be made once the chart is deemed "complete".**

E. The following information is not available for inspection or copying:

- Psychotherapy notes recorded by a mental health professional, in any medium, and maintained separately from the rest of the client's medical record. Psychotherapy notes document or analyze conversation during a private, joint, family or group counseling session. By definition psychotherapy notes do not include medication records, counseling start and stop times, treatment records,

results of clinical tests, diagnoses, functional status, symptoms, prognosis and progress and notes maintained with the individual's regular record.
- Information compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding or pending litigation.
- Incident reports generated when an error occurs are not included in the designated record set and thus requests to review this information by the client or their representative will be denied.

UNREVIEWABLE GROUNDS FOR DENIAL TO REVIEW AND/OR OBTAIN COPIES

Listed below are reasons/cases that would constitute denial for a client to inspect and/or obtain copies of their records, which are not contestable by the client or their representative:

• The PHI is exempted from the right of access above.

• The PHPI was obtained from someone other that a provider under a promise of confidentiality, and access would be reasonably likely to reveal the source of the information. If the client is denied access to their record information, the VYH must provide written explanation in plain language, containing basis for denial, a statement of the individual's review rights, and instruction on how to file a complaint.

REVIEWABLE GROUNDS FOR DENIAL TO REVIEW AND/OR OBTAIN COPIES

- A mental health provider and/or supportive housing provider has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the client or of another person
- The PHPI makes reference to another person who is not a mental health provider or supportive housing provider and a mental health professional and/or supportive housing provider has determined that the access requested is reasonably likely to cause substantial harm to such other person
- The request for access is made by the individual's personal representative and a mental health professional and/or supportive housing provider has determined that access is reasonably likely to cause substantial harm to the individual or another person

If the client is denied access to their record information VYH must provide written explanation in plain language, containing basis for denial, a statement of the individual's review rights, and instruction on how to file a complaint. The client may request that the denial be reviewed, in which case another mental health professional and/or supportive housing provider chosen by VYH will review the client's request and the denial. The person conducting the review will not be the person who denied the client's first request. If the denial is overturned the client will have the right to access their record. If the denial is upheld the client will be unable to access their records.

VYH will promptly provide written notice to the individual of the determination of the reviewing professional.

II. AMENDMENT TO HEALTH RECORDS AND CORRECTING PERSONAL INFORMATION– A client or their legal representative has the right to request that the agency amend his/her PHPI. The client has the right to request an amendment for as long as the records are kept by or for the agency. Such requests for amendments to the record must be in writing and must include a reason to support the amendment. All requests for amendment must be submitted to the Program Director. VYH must act on the client's

request for amendment no later than sixty (60) days after receipt of such request. VYH will have a one-time extension of up to 30 days for an amendment request if necessary, provided the covered entity gives the individual a written statement of the reason for the delay, and the date by which the amendment will be processed. If a client believes an entry in his/her record is incomplete or inaccurate upon inspection, the following steps are to be followed:

i. The client may initiate a Request for Amendment form (see form attached) that must be submitted to the Program Director.

ii. The mental health professional or case manager will assist the client in completing the form if necessary. Upon completion of the form the employee will give one copy to the client, file one copy in the record in question, and forward the original to the author of the entry.

iii. The author of the inaccurate/incomplete entry may review the record to determine the validity/feasibility of the addendum and following that review will complete the appropriate section of the amendment form, sign it and return it to the Program Director. The original form with the author's comments and signature will remain a permanent part of the client's record (replacing the copy, which was previously filed in the record at the time of the request).

iv. If an amendment is made based on the client's request, the Program Director will make a notation at the site of the information being amended indicating, "see amendment" and will date and sign that entry. The amendment form will be attached to the entry that was amended.

v. A copy of the completed amendment form will be sent to the client indicating that an amendment was made and will also be sent to others who have already received the information subject to the amendment and that may have relied or may rely on that information to the detriment of the client.

vi. Copies of the amendment form will also be furnished to additional individuals or organizations the client deems necessary as documented on the amendment form.

vii. Whenever a copy of the amended entry is disclosed, a copy of the amendment form will accompany the disclosed entry.

GROUNDS FOR DENIAL OF AMENDMENT

VYH may deny the request for amendment if the PHPI that is the subject of the request:

- was not created by the VYH
- is not part of the individual's designated record set
- is accurate and complete

If the request for amendment is denied, the client must be informed in writing, in plain language. Included in this notification to the client will be:

- The basis for the denial
- A description of how to file a complaint or disagreement
- A description of the organization's complaint process including the name and telephone number of a contact person or office
- A description of the complaint process for filing with the U.S. Secretary of DHHS.
- A statement that if the client does not submit a statement of disagreement, the individual may request that VYH provide the request for amendment and the denial with any future disclosure of the information that is the subject of the requested amendment.

If the client disagrees with the denial, VYH must permit the client to submit a statement of disagreement. VYH may provide a written rebuttal to the individual's statement of disagreement after review of the statement and submit that back to the individual.
The letter of disagreement from the client and the letter of rebuttal by VYH will both be kept on file within the client's record and will be included with any subsequent disclosures of the PHPI to which the disagreement relates.
Reference: American Health Information Management Association (AHIMA)
§ 164.524 Health Insurance Portability and Accountability Act of 1996

XV. ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION TO CLIENTS UPON THEIR REQUEST

All disclosures of PHI are required to be logged on an accounting log by the provider who makes the disclosure except for disclosures that are made:
1. For treatment, or payment;
2. To the client about the client;
3. In the agency CTS or for notification purposes to a public or private entity authorized to assist in disaster relief efforts;
4. Incident to a permitted use or disclosure;
5. Pursuant to an authorization made by the client;
6. As part of a limited data set;
7. Prior to the compliance date for HIPAA; or
8. That is not part of the client's record.

All other disclosures must be documented on the accounting log made for this purpose.
Examples include, but are not limited to:
1. Disclosures to regulatory bodies, e.g. DPH, FDA, OSHA;
2. Disclosures regarding abuse, neglect, domestic violence;
3. Disclosures made for judicial or administrative proceedings, such as responses to court orders or subpoenas;
4. Disclosures made to coroners/medical examiners

PROCEDURE STATEMENT:

1. Provider recording of disclosures on the accounting log:

A. Each client's record contains an accounting log where all disclosures are documented as the disclosure is made. The accounting log for disclosures of PHI will be kept in a hard copy format. The log will be attached to the record and contain the following fields:

1. The date of disclosure;
2. The name of the recipient of the information (organization, individual, etc) and address, if known;
3. A brief description of the PHI disclosed; and
4. The purpose of the data disclosed or a copy of the written request for disclosure in lieu thereof.

B. For disclosures that may be made many times for the same purpose to the same person or entity, the accounting may include the information noted above and then the frequency or number of disclosures noting the first and last dates.

2. Client requests to VYH to provide an accounting of disclosures:

The client must request the accounting in writing from the Program Director responsible for maintaining the record, using the attached form. Clients have the right to receive this accounting of disclosures of their protected health information made in the six years prior to the date on which the accounting is requested.

3. Requirements VYH must follow when responding to client requests for an accounting:

A. If such a request for accounting is made, the Program Director, has sixty (60) days to respond to the request, but may have a one-time extension of thirty (30) days to provide the accounting as long as the client is given a written notice of the reason for the delay and a date by which the accounting will be provided to the client.

B. An individual's right to receive an accounting of disclosures to an oversight agency or law enforcement official must be temporarily suspended if the agency or official provides a written statement that the accounting would be reasonably likely to impede the agency's activities and specifying the time for which the suspension is required. If the agency or official statement is made orally, the statement must be documented, including the identity of the agency or official making the statement. The individual's right to an accounting will be temporarily suspended subject to this statement for no longer than thirty (30) days unless a written statement is submitted during that time.

C. Should a client request an accounting during this suspension period, then VYH must provide an accounting within 60 days, but the list of disclosures must not include any information that was disclosed to the law enforcement agency during the period of suspension. The suspension notice must be maintained in a separate area from the client record. The client must not be informed of the suspension of the accounting requirement. The request for suspension notice will be kept for the life of the client's record.

D. The first request for an accounting in a twelve (12) month period is free to the client. Thereafter, VYH may charge a reasonable, cost based fee.

4. An accounting log will be obtained from any employee of VYH whenever a client requests an accounting.

5. The accounting log will be maintained for the life of the record.

Reference: § 164.528 Health Insurance Portability and Accountability Act of 1996

XVI. CLIENT COMPLAINT REGARDING USE AND DISCLOSURE OF PROTECTED HEALTH AND PERSONAL INFORMATION

1. The organization has identified the grievance process for receiving client complaints related to the privacy and security of PHPI.

2. Any client complaint relating to the privacy and security of PHPI will be handled in the same manner as outlined in the Client Rights and Responsibilities.

3. The client may register a complaint with the U.S. Department of Health and Human Services as outlined in the "Notice of Privacy Practices."

Reference: §164.520 Health Insurance Portability and Accountability Act of 1996

XVII. VERIFICATION OF INDIVIDUALS OR ENTITIES REQUESTING DISCLOSURE OF PROTECTED HEALTH INFORMATION AND PERSONAL INFORMATION

VYH staff may rely on the exercise of professional judgment in making a disclosure

- from the Client Tracking System
- from the Homeless Management Information System
- to others in the involvement in the individual's care
- When acting on a good faith effort to avert a serious threat to health and safety, when the disclosure is made to a person who is reasonably able to prevent or lessen the threat.

In all other situations the following process should be utilized:

1. Determine if a written authorization is specifically required. If so then the information cannot be released without the appropriate written authorization.

2. Verify the identity of the requestor;

3. Determine the requester's authority to access the PHPI and apply the minimum necessary standards as appropriate.

Verification

In situations where an authorization is not required and VYH staff receives a request from an individual or entity for disclosure of PHPI, the staff will utilize professional judgment, whatever verification means are available to them, and the following guidelines as appropriate to the situation to assist in determining whether disclosures should be made. Examples of occasions where authorization may not be required include, but are not limited to the following:

• Phone calls from clients requesting information about themselves

Verification requirements are met if the VYH staff member makes a good faith effort to determine the identity of requester using any of these guidelines below.

• VYH's CTS system and the HMIS may be used to verify a client's name, address, dates of service, social security number.

• An internal phone extension or VYH nametag may be used to identify a person who works for VYH.

• Knowledge of a person's voice may be used in any situation.

• A call back to a given office number and/or verification of an address of a known place of business may be used to determine if a caller can be verified.

• Knowledge of the requester's identity can be used in any situation.

• Asking another person to verify the requester's identity may be used in any situation.

• Presence of another institution's nametag may be used to verify a requester's identity.

• Speak with the client to obtain his/her approval for the disclosure.

• Legal identification of the person, such as a driver's license may be used to verify identity in any situation.

Authority

Once any requester's identity is verified, staff may use whatever means are available to them to determine the person's authority to have the information requested. Staff may only disclose minimum necessary information unless the request is solely for the client's treatment.

For example, billing staff are reminded that persons other than the client that are responsible for payment of the bill, may be given financial information that would assist in payment of the bill. However, clinical information on the bill must be handled according to applicable law and is not to be routinely disclosed.

Public Officials

In verifying the identity and legal authority of a public official or a person acting on behalf of the public official requesting disclosure of PHPI, VYH staff may rely on the following, if such reliance is reasonable under the circumstances, when disclosing the PHPI:

a) Presentation of an agency identification badge, other official credentials, or other proof of government status if the request is made in person;

b) A written statement on appropriate government letterhead that the person is acting under the authority of the government;

c) Other evidence or documentation form an agency, such as a contract for services, memorandum of understanding, or purchase order, that established the person is acting on behalf of the public official;

d) A written statement of legal authority under which the information is requested;

e) An oral statement of such legal authority if a written statement would be impractical;

f) A request that is made pursuant to a warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or administrative tribunal that is presumed to constitute legal authority.

Violations

• In the event that the identity and/or legal authority of an individual or entity cannot be verified, VYH staff will not make the requested disclosure of PHPI, and will report the request for PHPI to their immediate supervisor.

• Knowledge of a violation or potential violation of this policy must be reported to the VYH Privacy Coordinator.

Reference: §164.510 (b); §164.512 (j); §164.514 (h); Health Insurance Portability and Accountability Act of 1996

XVIII. MINIMUM NECESSARY DATA

VYH will make reasonable efforts to limit protected health and personal information (PHPI) when using or disclosing PHPI, or when requesting PHPI from another covered entity to the minimum necessary to accomplish the purpose of the use or disclosure or request. Minimum necessary provisions do not apply to the following:

- Disclosures to or requests by a health care provider for treatment
- Disclosures to the individual who is subject of the information
- Uses and disclosures for which an authorization is required
- Uses and disclosures required for compliance with the standardized HIPAA transactions
- Disclosures to the U.S. Department of Health and Human Services (DHHS) regarding complaints related to privacy and security
- Uses or disclosures as required by other laws

It is important to remember that use of PHPI to provide treatment/services and disclosure of PHPI to coordinate follow up care or placement for a client are exempted from this minimum necessary requirement, therefore:

- Any direct care provider involved in a specific client's treatment/care/services is allowed full access to the client's record information.
- When transfer to another health care provider/facility/homeless provider or discharge to follow up care is coordinated.

1. Minimum Necessary Use of PHPI by VYH Staff

A. VYH has identified persons or classes of persons in the workforce:

1. who need access to PHPI to carry out their duties
2. by category or categories of PHPI to which access is needed and
3. any conditions appropriate to such access

B. VYH makes reasonable efforts to limit the workforce's access to that which is needed to carry out their duties.

C.The VYH Information Security Practice lists the various electronic systems containing PHPI, the job titles requiring access to each system and the level of access rights within each system assigned to each job title. The Privacy Coordinator is responsible for updating this list twice yearly to ensure the granted system access is limited to the minimum necessary to carry out the duties of each job title.

D. Computerized records information is password protected (sharing of passwords is prohibited) and employees utilizing computers to access PHPI must follow all the directives in the following security policies outlined in the Computer Procedures Manual.

2. Acting Upon Request for Disclosure:

A. In the following situations, VYH may rely on a person's requested disclosure as the minimum necessary for the stated purpose in order to disclose the client's PHPI

1. To public officials as required by other laws (if the official represents that the request if for minimum necessary information).

2. To provide information to another health care or homeless provider.

3. To a professional staff member of VYH or a business associate of VYH in order to provide professional services to VYH (if this person represents that the request is for the minimum necessary information).

4. To a person requesting information for research purposes if representations are made by the researcher that comply with VYH Research Protocol requirements.

B. For disclosures of PHPI that VYH provides on a routine and recurring basis, the departments involved have standard protocols that are followed that limit the PHPI disclosed to the minimum necessary.

3. Making Requests

A. VYH staff must limit any request for PHPI to that which is reasonably necessary to accomplish the purposes of the request when asking another provider for PHPI.

B. For requests for PHPI that VYH makes on a routine and recurring basis, the departments involved have standard protocols that are followed that limit the PHPI requested to the minimum necessary.

4. VYH staff may not use, disclose or request a client's entire record except when the entire record is specifically justified or the amount needed to accomplish the purpose of the use, disclosure or request.

5. In some circumstances minimum necessary information cannot be determined by VYH, but by some other entity such as in the case of federally mandated transactions, when a client authorizes use or disclosure of more than the minimum necessary, or in the case of judicial warrant, court orders or subpoenas.

6. Whenever possible, VYH will determine some method of limiting the information that is used or disclosed. This may involve the use of de-identified data, use of a limited data set, or only granting access to certain parts of the PHPI for online viewing, or copying only pertinent parts of the record for disclosure.

7. Each Program will monitor and audit disclosures of PHI periodically to ensure that the minimum necessary data is released appropriately and implements improvements as needed.

Reference: § 164.514 Health Insurance Portability and Accountability Act of 1996

XIX. E-MAIL: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

VYH is committed to safeguarding client information in order to fulfill its mission to clients, and to operate in a manner that is consistent with applicable Federal and State laws and regulations. Therefore, no PHI may be e-mailed. None of the Valley Youth House lines are secure at this time.

Reference: VYH Computer Procedure Manual
HIPAA Patient Privacy Compliance Guide, Safeguarding Protected Health Information, Chapter 2500, January 2002

XX. FAXING OF PROTECTED HEALTH INFORMATION

VYH is committed to safeguarding client information in order to fulfill its mission to clients, and to operate in a manner that is consistent with applicable federal and State laws and regulations.

I. SENDING INFORMATION VIA FAX

A. Client information should be hand delivered or mailed whenever possible. Faxing of client information internally to authorized personnel within the agency is allowable at anytime to facilitate treatment, payment and health care operations, provided the guidelines outlined in this practice are adhered to.

B. Faxing of client information outside of the facility is allowable in situations when health information is needed immediately for client care purposes, continuing care placement, payment or when mail or courier delivery will not meet a necessary timeframe. The following types of information are protected by federal and/or state statute and may NOT be faxed without specific written client authorization, unless required by law.

C. Faxing of sensitive health information such as that dealing with mental health, chemical dependency, sexually transmitted diseases, HIV or other highly personal information is prohibited except in emergency client care situations as allowed by law.

D. The FAX machine in agency offices must not be accessible to the public and should only be accessible to staff directly involved in client care of those authorized to handle faxed information.

E. The faxed information must be accompanied by special FAX cover sheet specifically designated for faxing of client health information (see attached). Each page of intended FAX should be stamped or marked “confidential”.

F. Employees authorized to FAX client health information must confirm the accuracy of the FAX numbers and security of recipient machines by calling the intended recipients to verify the numbers and notify them that the FAX is on the way. Staff should request that someone is available at the receiving end to remove the FAX and deliver to the appropriate location. Staff sending the FAX must also request verification of the receipt of the intended FAX.

When possible, a FAX confirmation slip should be printed from the FAX machine for each outgoing transmission and machine operators must also verify that the intended destination matches the number on the confirmation. The confirmation should be attached to the document that was transmitted and kept as part of the client’s record. If the confirmation slip cannot be obtained from the FAX machine sender must attempt to verify receipt.

G. In the event of a misdirected FAX, recipient should be directed to immediately destroy the fax.

H. When possible in instances where faxes are regularly sent to the same recipients, program those FAX numbers into the machine’s memory to eliminate possibility of mis-routed transmittals.

II. RECEIVING INFORMATION VIA FAX

A. When expecting the arrival of a FAX containing personal health information, schedule with the sender whenever possible to ensure that the faxed documents can be promptly removed from the FAX machine.

B. Each building must designate employees who are authorized to handle client information who will be responsible to check fax trays at scheduled intervals and disseminate their contents to the appropriate responsible parties.

C. Staff responsible for routing faxed client information must be sure that they leave them in a secure/confidential location. Client information should never be left in high traffic public locations.

D. PHPI that is received from other health care locations should be placed in the client’s record.

E. If there is a need to destroy any information it must be done either by shredder or placed in a confidential/secured trash box. Client information must never be discarded in non-secured trashcans.

XXI. TELEPHONE/VOICEMAIL/ANSWERING MACHINE DISCLOSURE OF PHPI

VYH is committed to safeguarding client information that may be shared via telephone in order to fulfill its mission to clients and to operate in a manner consistent with applicable federal and state laws and regulations.

1) Staff may disclose PHPI that is directly relevant to a person's involvement in a client's care and, except in circumstances where this disclosure can be reasonably inferred, staff will obtain the client's agreement
2) If the client is calling to obtain information about him/herself staff shall verify identity of person(s) on the phone using information available in the CTS: e.g. last four digits of the social security number and date of birth. The verification requirements are met if VYH relies on the exercise of professional judgment or acts on a good faith belief in making a disclosure.
3) Client protected health and personal information (PHPI) shall not be left on voicemail/answering machines. Information left on answering machines/voicemail shall be generic in nature and not indicate services being performed or provider of such services.
4) The following points must also be followed when disclosing PHPI on the phone, on voicemail or answering machine:
   a. Divulge only information not requiring client authorization;
   b. Divulge only the information minimally necessary to meet the purpose of the request; and
   c. Provide for a confidential environment for telephone conversation
5) Management staff is responsible to monitor their staff's compliance with this policy.

REFERENCE: §164.514(h) Health Insurance Portability and Accountability Act

XXII. USE AND DISCLOSURE INVOLVING FAMILY AND FRIENDS

Except in circumstances where consent can be reasonably inferred, VYH will obtain the client's agreement to such use and/or disclosure, and provide the client with the opportunity to object. This discussion is documented in the client's record. Reasonable efforts will be made to identify individuals over the phone.

1. Disclosure is permitted under certain circumstances, according to the following procedure.

A. When the client is present

1. The client is given the choice of objecting and does not;
2. The client verbally agrees to the disclosure; or
3. Staff infers from the circumstances that the client would not object to the disclosure

B. When the client is not present, or is unable to understand or reply

1. Staff determines the disclosure is in the client's best interest and the disclosure is limited to the friend or family member's involvement in the client care;
2. If reasonable inferences indicated that it is the client's best interest to permit a friend or family member who is acting on the client's behalf, to be exposed to protected information

2. Discussion with the consumer regarding the consumer's choice must be documented in the consumer's record

Reference: §164.510 (b) Health Insurance Portability and Accountability Act of 1996

XXIII. USES AND DISCLOSURES OF PHPI WHERE AUTHORIZATION OR OPPORTUNITY FOR CLIENT TO AGREE OR OBJECT IS NOT REQUIRED

VYH may use or disclose PHPI without the written authorization of the individual or the opportunity for the individual to agree or object in the following situations.

I. Uses and Disclosures Required by Law

VYH may use or disclose PHI as required by law only when sections A, B or C below are met.

A. Disclosures about Victims of Abuse, Neglect or Domestic Violence

1. Except for reports of child abuse or neglect VYH may disclose PHPI about an individual whom VYH reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

• If the report is mandated by law, and the minimum necessary disclosure will be made to meet that law, VYH should make the report (e.g. abuse of elderly, person with mental retardation, and residents of long-term care facilities); or

• If the individual agrees to the disclosure (oral agreement is acceptable); or

• If the disclosure is authorized by law (but not mandated) and

- VYH believes (in the exercise of professional judgment) that the disclosures must be made to prevent harm, or

- The individual is incapacitated, and cannot agree, and the agency receiving the report indicates that the information is not intended to be used against the individual, and there is a need for the information immediately.

2. If the report is made, VYH must inform the individual, or his personal representative, that the report will be made unless the personal representative is suspected to be the person who caused the abuse or neglect, and disclosing to that personal representative would not be in the client's best interest. If disclosure is necessary to prevent or lessen harm to the client or others and state law permits the disclosure, the report may be made without disclosing the report to the client.

B. Uses and Disclosures for Health Oversight Activities

1. VYH may disclose PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

a. the health care system;
b. government benefit programs for which health information is relevant to beneficiary eligibility;
c. entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; and
d. Entities subject to civil rights laws for which health information is necessary for determining compliance.

2. A health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity, and such investigation or other activity does not arise out of and is not directly related to:

a. the receipt of health care;
b. a claim for public benefits related to health; or
c. Qualifications for, or receipt of, public benefits or services when a client's health is integral to the claim for public benefits or services.

C. Disclosures for Law Enforcement Purposes

VYH may disclose PHPI for a law enforcement purpose to a law enforcement official if the following conditions are met, as applicable:

1. Pursuant to Process and as Otherwise Required by Law

VYH may disclose PHPI:

a. as required by law including laws that require the reporting of certain types of wounds or other physical injuries, or
b. in compliance with and as limited by the relevant requirements of:
    - a court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;
    - a grand jury subpoena; or
    - an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, or similar process authorized under law, provided that:
        - ✓ the information sought is relevant and material to a legitimate law enforcement inquiry;
        - ✓ the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
        - ✓ De-identified information could not reasonably be used.

2. Disclosures of Limited Information for Identification and Location Purposes

VYH may disclose PHPI in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that:

a. VYH may disclose only the following information:

• Name and address;
• Date and place of birth;
• Social security number;
• Date and time of treatment;
• Date and time of death, if applicable; and
• a description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos.

3. Victims of a Crime

VYH may disclose PHPI in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime other than disclosures for public health activities or victims of abuse, neglect or domestic violence, if:

a. the individual agrees to the disclosure; or

b. VYH is unable to obtain the individual's agreement because of incapacity or other emergency circumstance provided that:

• the law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;

• The disclosure is in the best interests of the individual as determined by the VYH staff, in the exercise of professional judgment.

4. Crime on Premises

VYH will disclose to law enforcement official PHPI that VYH, in good faith, believes constitutes evidence of criminal conduct that occurred on the premises of VYH.

5. Reporting Crime in Emergencies

a. VYH, in providing emergency care in response to a crisis, other than an emergency on its own premises, may disclose PHPI to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

- the commission and nature of a crime;
- the location of such crime or of the victim(s) of such crime; and
- The identity, description, and location of the perpetrator of such crime.

b. If VYH believes that the emergency is the result of abuse, neglect or domestic violence of the individual in need of emergency care, this section does not apply and any disclosure to a law enforcement official for law enforcement purposes must be in accordance with Section I. A (Disclosures about Abuse, Neglect and Domestic Violence) of this practice.