

# MINIMUM NECESSARY DISCLOSURE OF PHI

**Policy:** When disclosing protected health information (PHI) to other organizations, the University of Connecticut will provide only the PHI that is necessary for the organization to accomplish the intended use of the data. When receiving PHI from other organizations, the University will rely on those to provide only the information needed to satisfy the University's needs with regard to that information.

**Rationale:** To maintain compliance with Title 45 CFR Parts 164.502(b) and 164.514(d), Minimum Necessary Requirements and to provide guidance to members of the University's HIPAA-Covered Components, directing them how to limit the release of PHI to the minimum necessary to accomplish the intended purpose of any use, disclosure, or request for PHI.

## **POLICY STATEMENT:**

The University will make reasonable efforts to limit use and/or disclosure PHI, or when requesting PHI from another covered entity, limit the scope of the request to the minimum necessary to accomplish the purpose of the use or disclosure or request.

This policy will not apply to:

- Uses by or disclosures to or requests by a health care provider for treatment/care purposes
- Disclosures made to the Individual described by or in the PHI
- Disclosures that are authorized by the Individual described by the PHI
- Uses and disclosures required for compliance with the standardized HIPAA transactions
- To disclosures that are made using "limited datasets" or data that have been "de-identified" so that they can no longer be directly associated with the Individual described by the PHI.
- Disclosures to the U.S. Department of Health and Human Services (DHHS) regarding complaints related to privacy and security
- Other uses or disclosures that are required by law.

## **A. General Procedures:**

1. The University will identify the functional roles of University employees, student, volunteers, affiliates and contractors who work in and/or with the University's HIPAA-Covered Components and determine the access to PHI that is appropriate for persons working in those roles.
2. The University will make reasonable efforts to limit access to the PHI that is needed to work in each of those roles.

3. The University will take reasonable precautions to make sure that PHI is not overheard or inadvertently provided to bystanders.
4. For any routine or recurring PHI disclosures, the University will limit the disclosures to the minimum amount necessary to achieve the purpose of the disclosure.
5. For all other disclosures, the University will review the requests for disclosure and limit the data provided to the amount that is the minimum necessary to achieve the intended purpose of the disclosure.

#### B. Minimum Necessary Use of PHI

1. Directors of the University's HIPAA-Covered Components shall identify members:
  - who need access to PHI to carry out their duties
  - by category or categories of PHI to which access is needed
  - any conditions appropriate to such access
2. Reasonable efforts shall be made to limit members' access to that which is needed to carry out their duties.
3. Computerized PHI shall be password protected (sharing of passwords is prohibited) and members utilizing computers to access PHI must follow all the directives in the University's HIPAA Security and other relevant University Security Policies.

#### C. Acting Upon Request for Disclosure

1. In the following situations, HIPAA-Covered Component members may rely on a person's requested disclosure as the minimum necessary for the stated purpose in order to disclose the Individual's PHI:
  - To public officials as required by other laws (if the official represents that the request is for minimum necessary information)
  - To provided information to another health care provider
  - To a professional staff member of the HIPAA-Covered Component or a business associate of the HIPAA-Covered Component in order to provide professional services to the University (if this person represents that the request is for the minimum necessary information)
  - To a person requesting information for research purposes if representations are made by the researcher that comply with IRB requirements under University policy.

2. For disclosures of PHI that the University provides on a routine and recurring basis, the HIPAA-Covered Components involved shall have standard protocols which are followed that limit the PHI disclosed to the minimum necessary.

D. Making Requests

1. HIPAA-Covered Component members must limit any request for PHI to that which is reasonably necessary to accomplish the purposes of the request when asking another health care provider for PHI.
2. For requests for PHI that the University makes on a routine and recurring basis, the HIPAA-Covered Components involved shall have standard protocols which are followed that limit the PHI requested to the minimum necessary.

E. Members of the University's HIPAA-Covered Components may not use, disclose or request an Individual'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.

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

G. Whenever possible, the University 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 PHI for online viewing, or copying only pertinent parts of the record for disclosure.

H. Each HIPAA-Covered Component will monitor and audit disclosures of PHI periodically to ensure that the minimum necessary data is released appropriately.

I. If it is determined that an access, use or disclosure of PHI does not comply with the minimum necessary standard for the particular access, use or disclosure, this must be reported to the University's Privacy Officer and/or Security Officer for breach evaluation.

Reference: § 164.514 Health Insurance Portability and Accountability Act of 1996 and as amended by HITECH as of 1/25/13