| TITLE<br><br>ADMINISTRATIVE SAFEGUARDS FOR PHI | NUMBER<br><br>IM-1:002 |
|---|---|
| SUBJECT<br><br>INFORMATION MANAGEMENT | EFFECTIVE<br><br>DATE 10/1/2019 |
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**PURPOSE:**

The purpose of this policy is to explain the administrative steps necessary that Behavioral Health Centers and affiliates must take in order to protect a patient's protected health information and to comply with federal HIPAA regulations.

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers and affiliates.

**RESPONSIBILTY:**

It is the responsibility of the Compliance Officer and Health Information Management to implement this policy and procedure and to disseminate this information to director level employees who will distribute this information to their employees.

**POLICY:**

It is the policy of Behavioral Health Centers and affiliates to comply with all federal HIPAA guidelines and Privacy regulations.

**PROCEDURE:**

**PATIENT RECORDS MANAGEMENT**

1. Patient records shall be confidential and maintained in a locked, secure area at all times while not in use by the staff of Behavioral Health Centers and affiliates. Patient records are the property of the facility and are maintained for the benefit of the patient and the facility and shall be utilized by professional staff to document all services rendered in accordance with licensure and accreditation standards.
    a. All staff shall ensure that no documentation with patient information is left unmonitored (i.e., printer, office desks, or computer monitors).
2. Documentation in records may not be deleted. Amendments or changes must be approved and documented.

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3. Behavioral Health Centers and affiliates shall assume the responsibility to safeguard the records and information contained within against loss, defacement, tampering or use by unauthorized persons. An important aspect of the patient's right to privacy relates to the preservation of the confidentiality of information contained within the patient record.
4. Distribution of PHI shall occur via fax, FedEx, or US Postal Service only.
5. Only appropriate employees will be granted access to Behavioral Health Centers and affiliate's electronic medical record (EMR). This system is password protected.
6. Assignment of patient medical record numbers shall be tracked and determined through the Intake department in an ongoing systematical order.
7. Behavioral Health Centers and affiliates has designated the Compliance Officer and Health Information Management to be responsible for:
    a. Maintaining the policies and procedures that are put in place to protect a patient's PHI.
    b. Receiving patient complaints.
    c. Publishing and posting the Notice of Privacy Practices.
8. Behavioral Health Centers and affiliates will create a process for patients to register complaints regarding potential violations of privacy.
9. Behavioral Health Centers and affiliates will investigate and document all patient complaints to conclusion by adhering to the Grievance & Appeal policy and procedure in place.
10. Behavioral Health Centers and affiliates will provide training to all newly hired employees on the policies and procedures with respect to patient PHI and annually thereafter.
11. Behavioral Health Centers and affiliates will institute appropriate administrative, computer technology, and electronic medical record safeguards to protect all patients PHI.
12. Direct supervisors, direct managers, and the Human Resources department will apply appropriate disciplinary actions for staff who fail to comply with the privacy policies and procedures of Behavioral Health Centers and affiliates
13. Behavioral Health Centers and affiliates will take appropriate actions to prevent further inappropriate uses or disclosures of PHI and pursue any feasible actions to lessen the harmful effects of any such violations.
14. It is the policy of Behavioral Health Centers and affiliates that its employees may not intimidate, threaten or take retaliatory actions against any individual or other person for exercising their rights under HIPAA or for participating in a process established by HIPAA.

15. It is the policy of Behavioral Health Centers and affiliates that it forbids intimidation or retaliation against anyone (patient or employee) for reporting a problem or filing a complaint.
16. The Quality Assurance and Health Information Management departments will develop procedures to make changes to the privacy policy and procedures as required by changes in law, changes in the Notice of Privacy Practices, or by Behavioral Health Centers and affiliates.

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**The role of the Compliance Officer and Health Information Management as it pertains to the Privacy Policy and addressing Complaints:**

1. The Compliance Officer and Health Information Management for Behavioral Health Centers and affiliates is responsible for the development and implementation of the policies and procedures for Behavioral Health Centers and affiliates.
2. Any complaint by a patient must go through the Compliance Officer and Health Information Management.
    a. The Compliance Officer and Health Information Management will explain how a patient can file a complaint with the U.S. Department of Health and Human Services (HHS) if that complaint is strictly regarding protected health information.
3. The Compliance Officer and Health Information Management for Behavioral Health Centers and affiliates will be the contact person that receives complaints and provide information regarding the Notice of Privacy Practices policy.

**EMPLOYEE ACCESS TO PATIENT PHI**

Behavioral Health Centers and affiliates will classify its employees and determine their level of access to a patients protected health information:

1. Executive Management: **Full access**.
2. Medical/Clinical Staff:

    a. Medical Doctors, Nurse Practitioners, Physicians Assistants:
        1. **Full access** to patient protected health information as it applies to:
            - General care.
            - Emergency care.
            - Medication orders, changes and prescriptions.
            - History & Physical and Psychiatric Evaluations and other pertinent notes.
            - Patient billing information is ***excluded***.

b. Client Services:
    1. **Limited access** granted for patient protected health information. Patient billing information is ***excluded***.

c. Clinical Therapists:
    1. **Limited access** granted for patient protected health information. Patient billing information is ***excluded***.

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d. Clinical Directors:
    1. **Broad access** granted for patient protected health information related to:
        - Assigning Teams and Programs.
        - Review of clinical medical record.
        - Approval of visits.
        - Approval of completed clinical documents.
        - Patient billing information is ***excluded***.

e. Nursing:
    1. **Broad access** granted for patient protected health information related to:
        - Medication administration and protocols.
        - Patient billing information is ***excluded.***

f. Contracted Clinical Therapists:
    1. Equine, Massage, Music, Art, and AVS Therapy: **Limited access** granted for patient protected health information and writing clinical notes in patients' electronic medical record.

g. Joint Commission Consultants: **Full access**.

h. State auditors: **Full access**.

3. Non-Medical Staff:
    a. Health Information Management: **Full access**.
    b. Human Resources: **Full Access** as it pertains to:
        1. The employment of Behavioral Health Centers and affiliates employees.
        2. All associated file management of employees.
        3. Training documentation.
        4. Performance reviews.
        5. Disciplinary actions.
        6. Patient's protected health information is ***excluded.***
    c. Intake Supervisor:
        1. **Limited access** granted for patient protected health information.

2.Patient billing information is ***excluded.***

d. Intake Coordinators:
    1.**Limited access** granted for patient protected health information.
    2.Patient billing information is ***excluded.***
e. Behavioral Health Technicians:
    1.**Limited access** granted for patient protected health information.
    2.Patient billing information is ***excluded.***

| TITLE<br><br>PRIVACY ACT OF PROTECTED HEALTH INFORMATION | NUMBER<br><br>IM-1:003 |
|---|---|
| SUBJECT<br><br>INFORMATION MANAGEMENT | EFFECTIVE DATE<br><br>07/01/2017 |
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**PURPOSE:**

The purpose of this policy is to make patients aware of the privacy rights that Behavioral Health Centers has created regarding the use and disclosure of their protected health information (PHI) and to describe the process for filing a complaint should patients feel those rights have been violated.

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the CEO to implement this policy. It is the responsibility of all director level employees to disseminate this information to staff under his/her direction.

**POLICY:**

It is the policy of Behavioral Health Centers to ensure adequate notice is given to all patients of their privacy rights related to health information; to inform patients of practices and duties regarding such information; and to describe the process for filing a complaint should patients feel those rights have been violated.

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**PROCEDURE:**

1. UBehavioral Health Centers will remain in accordance with the Privacy Act of 1974, 1975 U.S.C 522a, Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Part 164, Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, Confidentiality of Mental Health Records, 42 CFR Part 51 and the Freedom of Information Act, 5 U.S.C 552.
2. The Notice of Privacy Practices shall be posted in a clear and prominent location where it is reasonable to expect for patients to see and read.
3. The Notice of Privacy Practices must be written in an understandable manner.
4. A paper copy of the notice shall be available upon request for the patient to keep.
5. All patients shall, upon admission, be given the notice, provided an explanation, and asked to sign the acknowledgement portion.
    a. Notice must also be signed by the employee at time of patient's admission.
6. The signed notice shall become part of the patient record.
7. If a patient has questions, concerns, or refuses to sign the acknowledgement portion of the notice, they should be referred to the Clinical Director and/or designee.
8. A copy of the notice shall remain posted on the organization's website.
9. Whenever the language of the notice is revised, the revised notice shall be posted immediately and paper copies of the notice shall be available upon request.
10. Behavioral Health Centers will explain how it uses and discloses a patient's protected health information.
11. Behavioral Health Centers will explain how a patient can file a complaint with Behavioral Health Centers(refer to the Grievance & Appeal Procedure).
12. Behavioral Health Centers will explain how a patient can file a complaint with the U.S. Department of Health and Human Services (HHS) if that complaint is strictly regarding protected health information.

**REFERENCES:** Health Insurance Portability and Accountability Act.

| TITLE<br><br>AUTHORIZATION FOR RELEASE OF INFORMATION (ROI) | NUMBER<br><br>IM – 1:004 |
|---|---|
| SUBJECT<br><br>INFORMATION MANAGEMENT | EFFECTIVE DATE<br><br>07/01/2017 |
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**PURPOSE:**

The purpose of this policy is to ensure proper use of the ROI (ROI) form in obtaining patient consent to, or authorization of, use and disclosure of PHI (PHI).

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the all executive and director level employees to implement this policy and to disseminate this information to all employees under his or her direction.

**POLICY:**

It is the policy of Behavioral Health Centers that all employees engage in the proper use of the ROI in obtaining patient consent to, or authorization of, use and disclosure of PHI.

**PROCEDURE:**

1. An ROI consent form must be obtained prior to the use or disclosure of PHI. The ROI consent form must be signed and dated by the patient.
2. The ROI consent form completed through Behavioral Health Centers, **electronic medical record** will have the following information:
    a. The patient's full name.
    b. The full name of the person or organization, address and phone number, to which this information is to be disclosed to.
    c. A description of the PHI the patient is authorizing be released.
    d. The patient's acknowledgment is identified by checking box of their Authorization of the Release of Information regarding sexually transmitted diseases, including bloodwork, laboratory results, assessments and/or notes.
    e. How the PHI will be delivered: fax, email or phone.

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f. The patient's purpose for the use and disclosure of their PHI.
g. Expiration date. Unless otherwise stipulated, an authorization of the release of information is valid for 6 months.
h. Signature of patient and date consent form is completed.
i. Signature of employee and date consent form is completed.

3. The ROI consent form completed as a paper will have the following information:
    a. The patient's full name, date of birth, and last 4 numbers of their social security number.
    b. The full name of the person or organization to which this information is to be disclosed, including address and phone number.
    c. A description of the PHI the patient is authorizing be released
    d. The patient's acknowledgment (by checking box and initialing consent form) of their authorization of the release of information regarding sexually transmitted diseases, including bloodwork, laboratory results, assessments and/or notes.
4. How the PHI will be delivered, including the patient's phone number for follow-up purposes.
    f. The patient's purpose for the use and disclosure of their PHI.
    g. Expiration date. Unless otherwise stipulated, an authorization for release of information is valid for 6 months.
    h. Signature of patient and date consent form is completed.
    i. Signature of employee and date consent form is completed.
5. Additional information found within the ROI consent form:
    a. **Conditions:** Behavioral Health Centers, will not condition a patient's treatment on whether they give their authorization for the requested disclosure.
    b. **Form of Disclosure:** Unless specifically requested by the patient in writing that disclosure be made in a certain format, Behavioral Health Centers reserves the right to disclose information as permitted by the authorization in any manner. This includes: verbal, paper format, or electronically.
    c. **Re-Disclosure:** Federal law prohibits the person or organization to which disclosure is made from making any further disclosure of PHI unless it is expressly permitted by written authorization of the person to whom it pertains.
    d. **Requesting a copy of ROI**: The patient may request a copy of any and all ROI they may have completed while a patient at Behavioral Health Centers **Right to Revoke**: A patient may revoke, at any time, any and all Authorization for the Release of Information they have completed while a patient.

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## 6. REVIEWING ROI PRIOR TO RELEASING PHI:

a. The completed ROI consent form is to be returned to the Health Information Management department.
b. It is reviewed for completed content and errors.
c. If any content has been left unanswered or errors are discovered, the Health Information Management department will contact the patient and request additional information be added or request patient to complete a new ROI consent form.
d. If Health Information Management department approves the revised ROI consent form, then the process is started to provide the requested records to the patient.
e. Requested records are sent via fax, secure email, FedEx, U.S. Postal Service, or in person.
    i. Each page of the patient records shall be affixed with a “Confidential” stamp.

| TITLE<br><br>REQUEST FOR RESTRICTIONS OF USES AND DISCLOSURES / CONFIDENTIAL COMMUNICATIONS | NUMBER<br><br>IM-1:005 |
|---|---|
| SUBJECT<br><br>INFORMATION MANAGEMENT | EFFECTIVE DATE<br><br>07/01/2017 |
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**PURPOSE:**

The purpose of this policy is to enable patients to request restrictions on the use and disclosure of protected health information (PHI) for treatment, payment, and health care operations.

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the all executive and director level employees, in conjunction with Health Information Management to implement this policy and the responsibility of executive and director level employees to disseminate this information to all employees under his or her direction.

**POLICY:**

It is the policy of Behavioral Health Centers, to enable patients to request restrictions on the use and disclosure of protected health information (PHI) for treatment, payment, and health care operations.

| TITLE<br><br>REQUEST FOR RESTRICTIONS OF USES AND DISCLOSURES / CONFIDENTIAL COMMUNICATIONS | NUMBER<br><br>IM-1:005 |
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**PROCEDURE:**

1. A patient has the right to request restrictions of their PHI for:
    a. The use and disclosure of PHI for treatment, payment and health care operation purposes;
    b. Disclosure of PHI to family members, friends, and others involved in their care.
2. A patient has the right to choose which PHI is made available to be used or disclosed when they complete an Authorization for Release of Information (ROI) consent form.
3. A patient has the right to choose which person(s) or entities may have access to their PHI when they complete an ROI consent form.
4. Behavioral Health Centers is not required to agree to a patient's request to restrict PHI, but must abide by the request ***except in the following situations***:
    a. The information is needed to provide treatment.
    b. The information is needed to provide emergency services.
    c. It impedes the day-to-day operations of Phoenix Employee Solutions
5. Although an ROI consent form is completed by the patient and is limited with regard to who and what can be used or disclosed, this does not prevent Behavioral Health Centers, from disclosing information that is mandated by law and ***does not require the patient's consent or authorization***.
    **a.** HIPAA Privacy Rule expressly permits disclosures *without* individual authorization to public health authorities authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury or disability, including but not limited to public health surveillance, investigation and intervention.

**PATIENT REQUEST TO RESCIND RESTRICTED ROI:**

1. At any time a patient may choose to **rescind** any and all Authorizations for Release of Information they have completed.
2. Once rescinded the person(s) or entities named **can no longer have access to the patient's PHI** unless a new ROI is completed for said person(s) or entities.
3. Whenever an ROI consent form is rescinded it must be signed by the patient and the "rescind" box checked.
4. Indication of ROI being rescinded shall be noted on the form.

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| REQUEST FOR RESTRICTIONS OF USES AND DISCLOSURES / CONFIDENTIAL COMMUNICATIONS | IM-1:005 |
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**PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATION:**

1. Behavioral Health Centers, staff members must accommodate a patient's reasonable request to receive confidential communication by alternate means or alternate locations as follows, but not limited to:
    a. Patients may request contact via cell phone instead of home phone.
    b. Patients may request mail sent to a P.O. Box rather than a home address.
    c. Patients may request an alternate email address to be used.

2. All requested changes of email address, phone contact information and/or mailing address must be documented in the patient's electronic medical record.

3. A patient's request cannot prevent Behavioral Health Centers, from submitting claims to the patient's health care plan.

| TITLE<br><br>PATIENT RIGHT TO ACCESS PHI | POLICY NO.<br><br>IM-1:006 |
|---|---|
| SUBJECT<br><br>INFORMATION MANAGEMENT | EFFECTIVE DATE<br><br>02/13/2013 |
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**PURPOSE:**

The purpose of this policy is to establish guidelines, in accordance with Federal and State regulations, for addressing a patient's request to view, obtain a copy of, or amend their protected health information (PHI).

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the Health Information Management and Quality Assurance Departments to implement this policy. It is the responsibility of all director level employees to disseminate this information to his/her staff.

**POLICY:**

It is the policy of Behavioral Health Centers to establish procedures for addressing a patient's request to view, obtain a copy of, or amend their PHI.

**PROCEDURE:**

1. Behavioral Health Centers will recognize the patient's right to access their protected health information.
2. Behavioral Health Centers will respond for request for access to protected health information within thirty (30) days. If Behavioral Health Centers requires additional time to process a patient's request, the patient must be notified.
3. Behavioral Health Centers will accommodate the patient's right to lodge a complaint and appeal this process.

| TITLE<br><br>PATIENT RIGHT TO ACCESS PHI | POLICY NO.<br><br>IM-1:006 |
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4. Behavioral Health Centers will maintain accurate records and reports to demonstrate compliance of this policy.
5. Patient Request for Access to Protected Health Information – **In-treatment:**
    a. A patient who is **in-treatment** at Behavioral Health Centers may request to ***view*** their protected health information through their primary therapist.
    b. The patient's therapist or clinical director in the absence of a primary therapist may grant the request and allow the patient to view certain parts of their protected health information such as treatment plans and discharge plans. ***Exceptions*** *would be:*
        i. Psychiatric notes.
        ii. Information that could be used, or is being used in a legal matter involving the patient.
        iii. Information received from a confidential source(s).
        iv. Information involving suspected abuse.
        v. If in the judgement of the therapist the patient is considered emotionally unstable, and information (in part or whole), may cause the patient to harm themselves, this information should not be shared.
6. **Patient or patient's representative request for protected health information:**
    a. Patients or patient representative may request protected health information by completing and submitting an Authorization for Release of Information consent form.
    b. All requests for PHI must be forwarded to the Health Information Management (HIM) department.
    c. A "Request for Information" packet needs to be completed at time of request documenting the request and shall be maintained for seven (7) years.
7. **When requesting PHI (other than a patient actively in treatment), the following identifiers must be confirmed:**
    a. The last four numbers of the patient's social security number.
    b. Patient's date of birth.
    c. Patient's last known address given at time of most recent admission.
    d. The Health Information Management department compares signatures of returned Authorization to Release Information consent forms against signed documents in patient's medical record.
8. **Verification of active Authorization to Release Information consent form:**
    a. Authorization to Release Information consent forms must be checked to determine:

i. Who is named on Authorization to Release Information consent to receive the patients protected health information.
ii. What protected health information has the patient authorized can be released?
iii. Has the Authorization to Release Information consent form expired? If so, a new Authorization to Release Information consent form must be completed before any protected health information can be released.
iv. Has the Authorization to Release Information consent form been rescinded? If so, a new Authorization to Release Information consent form must be completed before any protected health information can be released.
v. Confirm that the requested protected health information is in fact within a Unity Behavioral Health LLC medical record.

9. Patients have the right to view and obtain a copy of their protected health information with some exceptions. **Reasons to Deny Access to Protected Health Information:**
    a. Confidential Communication:
        i. If a patient has requested confidential communications with Unity Behavioral Health LLC, before you provide protected health information to anyone, you must first get confidential approval from the patient.
    b. Protecting Confidential Sources of Information:
        i. Determine if the protected health information obtained by Unity Behavioral Health LLC contains information received from a confidential source(s). If so, this information, as well as the confidential source must be kept confidential.
    c. Risks of Harm:
        i. Determine if harm could come to the patient or others if access to protected health information is given. This question should be discussed with health care professionals most involved in the treatment of the patient. Examples:
            1. Suspected Abuse: Determine if the person requesting access to a patient's protected health information (in part or whole), where abuse is suspected, could be involved in the suspected abuse. No protected health information should be shared until suspicions are resolved.
            2. Emotional Instability: If in the judgement of a health care professional the patient is considered emotionally unstable, and information (in part or whole), may cause the patient to harm themselves, do not share protected health information without first taking steps to prevent such harm.

3. Other Person(s): If any of the information contained within the patient's protected health information is about someone other than the patient, and revealing this information could cause harm to the other person (excluding health care providers when the "information" pertains to the professional responsibilities to a patient), do not share that protected health information.
4. Legal Matters: Do not share any protected health information you believe may be used, or is being used in a legal matter involving the patient. This includes civil, criminal and administrative proceeding.
5. Audits or Investigations: Do not share any protected health information gathered for a government/regulatory action such as audits or investigations.
6. **Never** share psychotherapy notes. The only instance where releasing psychotherapy notes will be considered is when they are requested by subpoena from a judge. However, even a judicial subpoena MUST be thoroughly investigated by the Health Information Management department before psychotherapy notes can or will be released.
7. Inmate Requests: Patients who are currently incarcerated may read, but not receive copies of their protected health information without the approval of a prison/jail official and barring other restrictions found in the policy.

10. Denying Access to Protected Health Information:
    a. If access is denied in part, Behavioral Health Centers will give the patient access to any other requested protected health information after excluding the information to which access is denied; **OR**
    b. If access is denied in whole, Behavioral Health Centers will provide the patient with a timely written denial. The denial must be in plain language and:
        1. State the reason for the denial.
        2. Provide a description of how the patient may file a complaint with Behavioral Health Centers, and/or U.S. Department of Health and Human Services if information is strictly protected health information.
        3. Use caution when providing explanation for the denial to access protected health information so as not to reveal information that should be kept confidential, such as:
            a. An on-going criminal investigation.
            b. Suspicions of abuse.
            c. Confidentiality of the patient.
            d. Confidentiality of confidential sources.

| TITLE<br><br>DISCLOSING INFORMATION FOR OPERATIONS, AND TO OVERSIGHT AGENCIES OR PERSONAL REPRESENTATIVES | NUMBER<br><br>IM-1:007 |
|---|---|
| SUBJECT<br><br>INFORMATION MANAGEMENT | EFFECTIVE DATE<br><br>7/01/2017 |
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**PURPOSE:**

The purpose of this policy is to establish guidelines for employees to follow in the event they need to disclose the protected health information (PHI) of our patient(s) to personal representatives and other organizations with or without an Authorization for Release of Information (ROI) form on file.

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the Health Information Management (HIM) and Quality Assurance (QA) Departments to implement these policies and procedures. It is the responsibility of each employee's direct supervisor to disseminate it.

**POLICY:**

It is the policy of Behavioral Health Centers to establish guidelines for employees to follow in the event they need to disclose the PHI of our patient(s) to personal representatives and other organizations with or without an ROI form on file.

**PROCEDURE:**
**USE AND DISCLOSURE FOR HEALTH CARE OPERATIONS**

1. The uses and disclosures for purposes of health care operations are covered in the patient's consent for treatment form, so a specific authorization is not required. However, patient admission forms only cover the uses and disclosures for the following reasons/activities only:

a. Quality Assessment and Improvement
b. Professional Credentialing
c. Medical and Utilization Review
d. Legal Services
e. Auditing
f. Business Planning and Market Research
g. Grievance Procedures
h. Due Diligence Analysis
i. Creation of De-Identified Information
j. Customer Service
k. Compliance Monitoring

2. Patient consent is needed before using or disclosing PHI for payment for any functions incurred due to health care operations. The consent is to be completed with intake staff at admission.
    a. If a patient refuse to consent to the use and disclosure of PHI for purposes of payment and has not made an alternative provision to pay for services, Unity Behavioral Health LLC is not required to provide treatment.

**USE AND DISCLOSURE OF PHI FOR PAYMENT**

1. The uses and disclosures for purposes of payment are covered in the patient's consent for treatment form, so a specific authorization is not required.
    a. However, the uses and disclosures are limited to the following reasons/activities:
        i. Providing information to the patient's insurance provider to determine the patient's eligibility for benefits and coverage.
        ii. Submitting a claim for services to the patient's insurance provider.
        iii. Providing information needed by the patient's insurance provider to determine coverage, including information needed by the insurance provider to conduct a medical review.
    b. Refusal of Non-Emergency Treatment Without Consent For Purposes of Payment:
        i. If a patient refuses to consent to the use and disclosure of PHI for purposes of payment and has not made an alternative provision to pay for services, Behavioral Health Centers is not required to provide treatment.

| TITLE<br><br>DISCLOSING INFORMATION FOR OPERATIONS, AND TO OVERSIGHT AGENCIES OR PERSONAL REPRESENTATIVES | POLICY NO.<br><br>IM-1:007 |
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## USE AND DISCLOSURE OF PHI TO OVERSIGHT AGENCIES

1. Behavioral Health Centers staff may disclose PHI to government agencies such as the State Licensing Agency (DCF) and The Joint Commission, conducting audits and other purposes related to the oversight of Phoenix Employee Solutions
    a. Behavioral Health Centers staff is required to refer requests for PHI received from oversight agencies to the Director of QA & HIM.
    b. The Director of QA & HIM will review requests for PHI and obtain a legal opinion if they believe one is necessary before approving the disclosure of the requested information.

## USE AND DISCLOSURE OF PHI TO PERSONAL REPRESENTATIVES

1. A personal representative may act on behalf of the patient for the purpose of:
    a. Consenting & Authorizing the use and disclosure of PHI.
    b. Receiving information that otherwise would be sent to the patient.
2. Designation of a Personal Representative:
    a. A personal representative may be any individual with Power of Attorney (POA) or other legally recognized authority to make medical decisions on behalf of the patient if he or she is incapacitated or otherwise unable to make decisions.
    b. A patient may designate a personal representative on the proper consent forms.
    c. However, anyone with medical POA or other legal authority to act on behalf of the patient will be recognized as the personal representative instead.

**Authority of Personal Representative:**

a. If a patient is incapacitated, a personal representative may sign any form.
b. A personal representative may receive PHI concerning the patient that he or she requires to perform their legal duties to the patient.
    i. Example: Providing an informed consent to treatment.

3. Refusal to Recognize Personal Representatives:
    a. A Behavioral Health Centers staff member may refuse to disclose information to a personal representative if the staff member believes that disclosing such information may endanger the patient in any way.
        i. Any request for information from a personal representative of one of Behavioral Health Centers patients that may need to be refused should be forwarded to the Director of QA & HIM.

| TITLE<br><br>USE AND DISCLOSURE OF PHI TO OUTSIDE AGENCIES AND/OR BUSINESS ASSOCIATES | POLICY NO.<br><br>IM-1:008 |
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**PURPOSE:**

The purpose of this policy is to establish guidelines regarding relationships between the Business Associates of Behavioral Health Centers and its employees as well as the legal requirements of disclosing PHI to such entities.

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the Health Information Management and Quality Assurance Departments to implement these policies and procedures. It is the responsibility of director level employees to disseminate this information to his/her staff.

**POLICY:**

It is the policy of Behavioral Health Centers to establish guidelines regarding relationships between the Business Associates of Behavioral Health Centers and its employees as well as the legal requirements of disclosing PHI to them.

**PROCEDURE:**

1. The Business Associate may use PHI for:
    a. Treatment, payment, and health care operations.
    b. Proper management and administration of Business Associate.
    c. To carry out the legal responsibility of the Business Associate.
2. In order for a Business Associate to receive PHI, the disclosure must be required by law or the Business Associate must obtain reasonable assurances.
    a. The assurance must be that the PHI will be held in confidence and used only

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as required by law.

b. The Business Associate must draft a contract specifying reasonable assurances that is then signed and maintained by both Behavioral Health Centers and the Business Associate.

3. Satisfactory Assurance
    a. A Satisfactory Assurance must be obtained by Behavioral Health Centers, as required by law, if a Business Associate is to perform a function or activity on behalf of Phoenix Employee Solutions
        i. A Satisfactory Assurance must be documented through a written contract or other written agreement.
    b. Additionally, if an individual or organization provides services for Behavioral Health Centers, during which time there is a potential that they may access PHI, a Satisfactory Assurance must be included in their contract.
4. Process of preparing a Satisfactory Assurance
    a. Draft a document that provides the Satisfactory Assurance.
    b. Send the document to the Business Associates for review and execution.
    c. If assurances are not received, document the attempts and the reasons that such assurances cannot be obtained.
    d. Be sure the documents are dated and signed.
    e. File and retain these documents.
5. A Business Associate Contract is not required if:
    a. The individual or organization is required by law to carry out a function or activity on behalf of Phoenix Employee Solutions
        i. They may disclose PHI as necessary for the individual or organization to meet the requirements of the law.
        ii. Behavioral Health Centers must still attempt in good faith to obtain Satisfactory Assurances, and if such attempts fail, must document the attempt and reason of its failure.
    b. The disclosure is to a health care provider for the treatment of a patient.
6. Memorandum of Understanding
    a. If Behavioral Health Centers and its Business Associate are both Behavioral Health Centers entities, you may enter into a memorandum of understanding with the Business Associate.
    b. This memorandum must comply with business association rules as stated in §164.504(e).
        i. Draft a memorandum of understanding.

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   ii. Send the document to the Business Associate for review and execution.
   iii. Be sure the documents are dated and signed.
   iv. File and retain the contract or agreement.

7. Breach of Confidentiality or Noncompliance
   a. If Behavioral Health Centers knows or suspects that the Business Associate, or a person to whom the Business Associate discloses information to, engaged in a pattern of activity or practice that was a material breach or violation with the written agreement, Behavioral Health Centers must do the following:
      i. Take immediate steps to prevent further breaches or violations.
      ii. Take immediate action to mitigate harm caused by the breach or violation in writing.
      iii. Notify the Business Associate of the breach or violation in writing.
      iv. The Business Associate must take action to end the breach or violation and prevent further occurrences.
      v. Document this process in writing and retain for a period of seven (7) years.
8. Terminate the Relationship
   a. If the Business Associate does not take reasonable steps to rectify the breach or end the violation, or if reasonable steps are unsuccessful, you must terminate the contract. Behavioral Health Centers must:
      i. Draft a letter to the Business Associate notifying them that the contract is being terminated and indicate the reasons for termination.
      ii. Be sure the notice is dated and signed.
      iii. Send the termination to the Business Associate by certified mail, receipt requested, for proof of receipt.
9. Report the Problem
   a. If termination is not feasible, report the problem to the Secretary of the Department of Health and Human Services and then:
      i. Draft a letter to the Secretary of the Department of Health and Human Services outlining breach or violations.
      ii. Be sure the notice is dated and signed.
      iii. Send the report by certified mail, receipt requested, for proof of receipt.
      iv. File and retain a copy of these documents.

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**IN THE EVENT OF AMENDED PATIENT PHI**

1. If Behavioral Health Centers **agrees** to a patient's request for an amendment of patient protected health information, in whole or in part, Behavioral Health Centers must:
    a. Obtain the patient's agreement to notify other relevant person(s) or organization(s) with whom Behavioral Health Centers has shared, or now needs to share the amended information with, and
    b. Make a reasonable effort to inform and to provide the amended information within an appropriate timeframe to:
        i. Persons or organizations the patient names as having received non-amended protected health information; and
        ii. Persons, including Business Associates of Behavioral Health Centers which now has the PHI that is the subject of the amendment and that may have relied on, or could foreseeably rely on the information to the patient's detriment.

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**PURPOSE:**

The purpose of this policy is to establish guidelines for employees to follow in the event they need to disclose the protected health information of our patient(s) without their consent.

**SCOPE:**

This policy and procedure applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the HIM and QA Departments to implement these policies and procedures. It is the responsibility of each employee's direct supervisor to disseminate it.

**POLICY:**

It is the policy of Behavioral Health Centers to establish guidelines for employees to follow in the event they need to disclose the protected health information of our patient(s) without their consent.

**PROCEDURE:**

It is the policy of Behavioral Health Centers that the Director of QA and HIM be informed and involved in all of the following situations.

Any and all disclosures must comply with 45 CFR 164 in its entirety.
Any and all disclosures must be applicable with law and ethical standards.
**Reporting Abuse, Neglect, and/or Domestic Violence**
**Mandatory Reporting**

1. Behavioral Health Centers Staff are required to report cases of suspected child abuse or neglect to State or Local Child Abuse and Neglect Agencies as required by law.

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2. Reports of Child Abuse to the above named agencies do not require the consent or authorization of the patient.
    a. However, only absolutely necessary information pertaining to the child abuse is to be disclosed.
    b. The patient will be informed that suspected child abuse or neglect cases will be reported.

**Non-Mandatory Reporting**

1. Staff may report cases of suspected child abuse or neglect to State or Local Child Abuse and Neglect Agencies without the consent or authorization of the patient if the following criteria are met:
    a. The patient's physician believes that the report may prevent serious injury to the patient or others.
    b. The disclosure is permitted under federal or state law

2. Staff are to disclose only that information that is permitted by law to be disclosed.

**Voluntary Reporting**

1. Staff may report cases of suspected child abuse or neglect to State of Local Child Abuse and Neglect Agencies with the patients consent or authorization.
    a. This authorization must come in writing in the form of an authorization for release of information form.
    b. Disclosure should be restricted only to the types of information that are required by law to be disclosed.

    The following apply when PHI is disclosed to the State or Local Child Abuse and Neglect Agencies:
        a. The patient must be informed of the disclosure.
            i. Unless the patient's physician believes informing the patient could lead to serious harm for the patient or another person.
        b. If the patient cannot be informed, the emergency contact person the patient has listed in their medical chart is to be informed.
            i. Unless the patient's physician believes informing the emergency contact could lead to serious harm for the patient or another person.

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**Disclosure of Patient Information to Law Enforcement Agencies**

It is the policy of Behavioral Health Centers to only release patient PHI without their written consent or authorization, by the HIM Department and under the specific circumstances summarized below:

1. To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena.

2. To respond to an administrative request.
   a. Includes administrative subpoena.

3. To respond to a request for PHI for purposes of identifying or locating of a suspect, fugitive, material witness, or missing person; but Behavioral Health Centers will limit its disclosures to the minimum required as seen here:

   a. Name and Address
   b. Date and Place of Birth
   c. Date and Time of Treatment
   d. Description of the patient's distinguishing physical characteristics.

4. The same limited information may be reported to law enforcement:
   a. About a suspected perpetrator of a crime when the crime is committed against an employee of Phoenix Employee Solutions
   b. To identify or apprehend an individual who has admitted participation in a violent crime.

5. To respond to a request for PHI about a victim of a crime and the victim is agreeable.

6. To alert law enforcement to the death of an individual
   i. 45 CFR 164.512 (f)(4)

7. To report PHI that Behavioral Health Centers, in good faith, believes to be evidence of a crime that occurred on Behavioral Health Centers premises.

8. To a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public
   i. 45 CFR 164.512 (j)(1)(i)

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9. To identify or apprehend an individual who appears to have escaped from lawful custody
    i. 45 CFR 164.512 (j)(1)(ii)(B)

10. For certain other specialized governmental law enforcement purposes:
    a. To Federal officials authorized
        i. 45 CFR 164.512 (k)(2) & 45 CFR 164.512 (k)(3)
    b. To respond to a request for PHI by correctional institution or law enforcement official having lawful custody.

**Disclosure Due to Disastrous Event**

1. In the event Behavioral Health Centers, experiences a disastrous event, and is in need of the assistance of Disaster Relief Agencies, patient PHI can be released without consent of the patient.
    a. The PHI allowed to be disclosed must be the minimum necessary for the Agency to complete their duty.

**Disclosure of PHI after Death**

1. PHI of a patient of Behavioral Health Centers who has passed away is still held to the standards of a patient who is living, in regards to its disclosure.
    a. See 45 CFR 164.510

| TITLE<br><br>REQUESTING & DISCLOSING PHI - OUTSIDE AGENCIES | POLICY NO.<br><br>IM-1:010 |
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**PURPOSE:**

The purpose of this policy is to establish guidelines, in accordance with Federal and State regulations, for both disclosing and requesting the protected health information (PHI) of patients.

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the Health Information Management and Quality Assurance Departments to implement this policy. It is the responsibility of all director level employees to disseminate this information to his/her staff.

**POLICY:**

It is the policy of Behavioral Health Centers that the following established guidelines, in accordance with Federal and State regulations, for both disclosing and requesting protected health information of patients are followed.

**PROCEDURE:**

**REQUESTING PHI FROM OUTSIDE AGENCY FOR CURRENT PATIENT**

1. A patient can authorize Behavioral Health Centers employees to obtain PHI from other facilities the patient has attended in the past, if medically or clinically necessary.
2. An Authorization for Release of Information (ROI) must be completed by the patient in order for Behavioral Health Centers to receive patient PHI from the outside agency.
3. The following must occur in order to obtain PHI **from outside agencies**:
    a. Staff must meet with the patient requesting to have his/her information disclosed.
    b. Explain the ROI process in its entirety to the patient and allow them to decide what information Behavioral Health Centers is authorized to receive. Select what the patient chooses on the form.

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c. Obtain and document the patient's demographic information on the form.
d. Obtain and document the name of the outside agency, representative name, mailing address, and fax number.
e. Have the patient review the completed form, sign and date on the appropriate lines.
f. Staff witness should sign and date the form.
g. Form shall be scanned into the patient's electronic medical record if not already completed electronically.
h. Verify with a representative of the outside agency that the location the ROI is being sent is correct and secure.
i. Send the completed ROI.
j. After a reasonable amount of time, depending on the method chosen to send the ROI, confirm with the facility its receipt of the ROI.
k. Document this process in an ancillary note in the patient's chart.
l. Upon confirmation that the PHI has been received by the outside agency, save the forms into the patient's chart.

**DISCLOSURE OF PHI TO OUTSIDE AGENCIES**

Before disclosing any patient PHI, an Authorization for Release of Information form (ROI) is to be fully completed by the patient.

**Use of a Behavioral Health Centers ROI form:**

1. Meet with the patient requesting to have his/her information disclosed.
    a. If it is a patient who is **no longer in our care**, an ROI can be sent to the patient for them to complete utilizing the instruction sheet to be sent with ROI.
2. Explain the form in its entirety to the patient and allow them to decide what information Unity Behavioral Health LLC is authorized to disclose. Select what the patient chooses on the form.
3. Fill in the remainder of the form including the needed patient demographics, contact information of the person receiving the information and expiration date.
4. Have the patient review what was completed form and sign and date on the appropriate lines.
5. Sign off as the staff witness and enter the date.
6. Scan the form into the patients electronic medical record if not already completed electronically.
    a. This includes ROI's completed by patients not currently in treatment.

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**Use of Outside Agency ROI form:**

In the event that an outside agency or entity wishes to obtain the PHI of a current or past Behavioral Health Centers patient, ***and*** the patient has already completed one of the agency's ROI's, the following steps must be followed:

1. Outside agency must send a copy of their ROI to the Health Information Management (HIM) Department.
    a. In the event another Behavioral Health Centers employee receives the ROI, they must submit it to the HIM department.
2. HIM employee must verify that the patient's demographics match the information on file.
    a. Example: Full Name (Including Spelling), DOB, and SSN.
3. HIM employee must verify that the release explicitly lists "Behavioral Health Center's" or "Behavioral Health Centers" as to who is releasing information.
4. HIM employee must verify that the agency or entity that is requesting information is listed as who is to obtain this information.
5. HIM employee must confirm there is an expiration date listed and that it has not elapsed.
6. HIM employee must match the patient's signature on the ROI to that found in Behavioral Health Centers records.

**VERIFICATION REQUIREMENTS FOR DISCLOSURE OF PHI**

1. As discussed, the ROI can be a Behavioral Health Centers ROI **OR** an ROI from another entity/outside agency.
2. Behavioral Health Centers employees will then verify the identity of any individual or organization requesting PHI, if the identity or authority is not already known to Behavioral Health Centers
3. PHI disclosure may be restricted by a previous patient request. The patient's records must be checked to be sure disclosure of information has not already been restricted.
4. In every case, Behavioral Health Centers employees should exercise professional judgment in determining whether or not a disclosure of PHI is justified.

| TITLE<br><br>PATIENT RIGHT TO REQUEST AMENDMENTS TO PHI | NUMBER<br><br>IM-1:011 |
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**PURPOSE:**

The purpose of this policy is to explain a patient's right to amend their protected health information, and what steps Behavioral Health Centers must take to comply or deny the request to amend.

**SCOPE:**

This policy applies to all executive and director level employees, clinical employees as well as Health Information Management department.

**RESPONSIBILITY:**

It is the responsibility of the director level staff to implement this policy and the responsibility of director level staff to disseminate this information to all employees under their direction.

**POLICY:**

It is the policy of Behavioral Health Centers to provide patients with the right to request an amendment of their protected health information within their designated medical record.

**PROCEDURE:**

1. Behavioral Health Centers requires patients to make requests for amendment in writing by completing the "Amendment of Health Record Request" form and providing a reason to support the amendment.
    a. The "Amendment of Health Record Request" form can be requested by contacting the Health Information Management department.
2. Behavioral Health Centers will respond to requests to amend PHI **within sixty (60) days**.

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3. Behavioral Health Centers may have a **one-time extension** of up to thirty (30) days for an amendment request provided Behavioral Health Centers gives the patient a written statement of the reason for the delay and the date by which the amendment will be processed.
4. Behavioral Health Centers, will document the request for amendment of PHI by completing the second part of the "Amendment of Health Records Request" form – whether denied or accepted.
    a. Form shall be scanned into patient's electronic medical record.
    b. Subsequent actions will be documented in an Ancillary Note in the patient's medical record.
5. Health Information Management department, Clinical Director, and executive level staff will review the request for amendment and determine if Behavioral Health Centers, will grant or deny the request.
    a. Behavioral Health Centers can only amend information created by Behavioral Health Centers.
6. If Behavioral Health Centers AGREES to the request for the amendment, Behavioral Health Centers must:
    a. Inform the patient that the amendment is accepted.
    b. Insert the amended information at the site of the documentation that is the subject of the request for amendment.
    c. Obtain, if necessary, an Authorization for Release of Information consent form from the patient to have Behavioral Health Centers notify the person(s) or organization with whom the amended information needs to be shared.
    d. Make a reasonable effort to inform and to provide the amended information within a reasonable time to:
        i. Persons or organizations the patient names as having received non-amended protected health information; and
        ii. Persons, including business associates of Behavioral Health Centers, which now have the protected health information that is the subject of the amendment and that may have relied on, or could foreseeably rely on the information to the patient's detriment.
7. Behavioral Health Centers MAY DENY THE REQUEST if it determines that the protected health information that is the subject of the request:
    a. Is accurate and complete.
    b. The requested amendment information is not part of the specifically requested medical record.
    c. The requested amendment information was not created by Behavioral Health Centers

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8. If Behavioral Health Centers DENIES the request for the amendment, Behavioral Health Centers must provide the individual with a timely denial letter written in plain language that contains:
    a. The reason for the denial.
    b. The patient's right to submit a written statement disagreeing with the denial and an explanation on how the patient may file such a statement.
    c. A statement that if the patient does not submit a statement of disagreement, the patient may request that Behavioral Health Centers provide the patient's request for amendment and denial with any further disclosures of protected health information.
    d. A description of how the patient may lodge a complaint with Behavioral Health Centers, and/or the Secretary of Health and Human Services.
    e. The name (or department), and telephone number of the designated contact person who handles complaints for Behavioral Health Centers
    f. Behavioral Health Centers may create a written rebuttal to the patient's statement of disagreement.
        1. Whenever such a rebuttal is created, Behavioral Health Centers must provide a copy to the patient who submitted the statement of disagreement.
9. Behavioral Health Centers will accommodate the patient's right to disagree with any denial of a request for amendment to protected health information, and will document this disagreement if further requested.
10. Will retain all documentation relating to requests for amendments by patients for a minimum of seven (7) years.

**DENYING A PATIENT'S REQUEST TO ACCESS THEIR INFORMATION:**

1. If access is denied <u>in part</u>, Behavioral Health Centers will give the patient access to any other requested protected health information after excluding the information to which access is denied; or
2. If access is denied <u>in whole</u>, Behavioral Health Centers will provide the patient with a timely written denial. The denial must be in plain language and:
    a. State the reason for the denial.
    b. Provide a description of how the patient may file a complaint with Behavioral Health Centers, and/or U.S. Department of Health and Human Services if information is strictly protected health information.
3. If a patient is denied access to their protected health information due to reasons that access may cause harm to the patient, or place the patient or another person in danger, Behavioral Health Centers will explain the patient's right to appeal, and include an explanation of how the patient may exercise these rights.

| TITLE<br><br>ACCOUNTING FOR DISCLOSURE OF PHI | POLICY NO.<br><br>IM-1:006 |
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**PURPOSE:**

The purpose of this policy is to explain the process for providing an accounting of a patient's protected health information (PHI).

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the Health Information Management and Quality Assurance Departments to implement this policy and to disseminate this information to Behavioral Health Centers employees.

**POLICY:**

It is the policy of Behavioral Health Centers to keep an accounting of when and whom disclosures of their PHI are made for purposes other than treatment, payment and health care operations and will provide an accounting to a patient if requested.

**PROCEDURE:**

1. **Maintenance of Disclosed Records**
    a. The HIM Department will create and maintain a system for documenting all disclosures of protected health information for which an individual may request an accounting of.
    b. Disclosures of PHI that Behavioral Health Centers is not required to report to its patients include:
        i. Any Disclosure for the purpose of treatment, payment, or disclosures previously authorized by the patient via an ROI.
        ii. Any disclosure directly to the patient.
        iii. Any disclosure for use in a facility directory.
        iv.

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v. Any disclosure to national security or intelligence agencies that is required by law.
vi. Any disclosure to correctional institutions or law enforcement agencies that is required by law.
vii. Any disclosure that occurred prior to April 14th 2003, the effective date of the HIPAA privacy rules.

2. **Requesting an Accounting of Disclosure**
   a. Any patient who indicates to any staff member that they would like to receive an accounting of disclosures should be told to contact Behavioral Health Centers HIM Department.
      i. All requests must be made in writing using the "Request for Accounting of Disclosures of Protected Health Information" form. This form is available through the Health Information Management department.
   b. As long as the patient's access is not currently being denied as the result of law enforcement or health oversight agency's request for a suspension of the patient's right to receive accounting of disclosure, the HIM Department will initiate preparation of an accounting.
   c. Patients can request an accounting of disclosures for a period of up to six (6) years prior to the date of the request, but not earlier than April 14, 2003.
   d. Behavioral Health Centers must act on a patient's request no later than sixty (60) days after receiving the request.
   e. All "Request for Accounting of Disclosures of Protected Health Information" form completed by patients must then be scanned into their **electronic medical record** in the attachments section.
   f. If information is found in a **paper medical record**, the Request for Accounting of Disclosures of Protected Health Information" form, must be placed in that medical record.
   g. The request should include the specific time period for the accounting but **cannot** include a time period prior to April 14, 2003, nor be a period of more than six (6) years.
   h. Using data found within the Behavioral Health Centers electronic medical record, the Health Information Management department will compile a report of the disclosures made for purposes other than treatment, payment and health care operations.
   i. Health Information Management will enter a note in the ancillary note section of the patient's medical record that information was provided to the patient.
   j. Any questions or concerns regarding documentation and/or release of disclosures should be referred to Health Information Management

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3. **Information to be provided in an Accounting of Disclosure**
    a. The date of disclosure
    b. The name of the entity or person who received the PHI
    c. A brief description of the purpose of the disclosure and/or a copy of the ROI used to disclose PHI.

**NOTE**: Disclosure to business associates that are covered under the patient's authorization for release of information for purposes of treatment, payment, and health care operations should not be included in the accounting.

4. **Suspension of a Patient's Right to Receive an Accounting of Disclosure**
    a. A law enforcement or health oversight agency may request the provider to suspend the right of a patient to receive an accounting of disclosures.
        - The request must come in writing, and should state how the accounting of disclosures would impede the agency's activities and a time period it is to remain active.
        - Verbal requests will not be considered until they are confirmed in writing.
    b. When a request to suspend this right is received, the following should take place:
        - The law enforcement or health agency official should be directed to the Director of Quality Assurance and HIM.
        - The Director of Quality Assurance and HIM will verify the credentials of the official, and document their identity and agency.
        - The Director of Quality Assurance and HIM will then place the patient's name on the list of those whose right to an accounting has been suspended pursuant to an official request.
5. **Documentation of Accounting Provided to Patients**
    c. A copy of any accounting provided to a patient will be retained for a period of seven (7) years from the date the accounting is provided.
6. **Charging for Accounting of Disclosure**
    d. Patients of Behavioral Health Centers are permitted to receive one (1) free copy of the accounting of disclosure in a 12-month period.
    e. Each additional request within the 12-month period will incur a $10.00 fee. If the patient agrees to pay the fee, then the accounting of disclosure will be provided.

| TITLE<br><br>INVESTIGATION OF POTENTIAL PRIVACY VIOLATIONS | NUMBER<br><br>IM-1:012 |
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**PURPOSE:**

The purpose of this policy is to establish guidelines to follow in the event that a Behavioral Health Centers employee or Business Associate is suspected of, or found to have, violated the policies and procedures in place to protect patient PHI.

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of Health Information Management and Quality Assurance Departments to implement these policies and procedures. It is the responsibility of each employee's direct supervisor to disseminate it.

**POLICY:**

It is the policy of establish guidelines to follow in the event that a Behavioral Health Centers employee or Business Associate is suspected of, or found to have, violated the policies and procedures in place to protect patient PHI.

**PROCEDURE:**

**Investigation of Staff Members**

1. Upon being notified of a potential violation of privacy by a staff member, the HIM Department along with the department director will:
    a. Review any documentation that has been prepared.
    b. Meet with the individual who reported the possible violation.
    c. Meet with the staff member(s) who may have violated the policies and procedures.
    d. Determine what, if any, PHI was used or disclosed.

e. Determine whether or not the use or disclosure violated any Behavioral Health Centers policy and procedures.
f. Determine whether the violation was accidental or intentional.
g. Recommend to the staff member(s) supervisor the disciplinary action, if any, that should be taken.
h. Document the findings of the investigation and action taken.

**Investigation of Contractual Breaches**

1. Upon being notified of a potential violation of privacy policies a procedures by staff member, the HIM Department along with the department director will:
    a. Contact the Business Associate and determine whether a contractual provision has been violated.
    b. If a contractual provision has indeed been violated, the HIM department will identify steps to be taken by the Business Associate that will enable them to comply with their contractual obligations.
    c. Review the corrective actions with the Business Associate and determine whether those steps or other measures will correct the violation.
2. If an agreement can be reached between Behavioral Health Centers and the Business Associate:
    a. The corrective measures will be summarized in writing and sent to the Business Associate.
    b. The HIM Department will monitor the implementation of the corrective action by periodically contacting the Business Associate.
    c. The HIM Department may discontinue monitoring after receiving adequate assurances the corrective actions have been and will continue to be implemented.
3. If it is not possible to develop an acceptable corrective action plan, the Director of HIM should implement the procedures to terminate the contract between Behavioral Health Centers and the Business Associate in question. In addition:
    a. An alternative source for the services provided by the Business Associate should be identified.
    b. The matter should be referred to Behavioral Health Centers legal counsel & HR Department with a request that formal action be taken to terminate the contract.
    c. The Business Associate should be notified by Behavioral Health Centers legal counsel that action will be taken to terminate the contract if the corrective actions are not immediately implemented.

   d. The status of the contract should be monitored by the HR Department and arrangements should be made to replace the business associate when the contract is formally terminated.
4. If the contract cannot be terminated, the contract violation should be reported to HHS by Unity Behavioral Health LLC legal counsel.

**Information Security Breach**

1. Behavioral Health Centers has an Information Security Breach Response Plan put in place to ensure compliance in handling any information breach.
2. Plan is attached and details a step by step action plan.
3. Plan includes all forms needed to be completed.
4. Plan includes main contacts for Behavioral Health Centers with their contact information for quick reference.
5. All staff has been trained and educated on appropriate procedure for handling an information breach.

**NOTE: Information Security Breach Response Plan attached.**

| TITLE<br><br>REPORTING SUSPECTED VIOLATIONS OF PRIVACY | NUMBER<br><br>IM-1:014 |
|---|---|
| SUBJECT<br><br>INFORMATION MANAGEMENT | EFFECTIVE DATE<br><br>07/01/2017 |
| REVIEW DATES | PAGE (S)<br><br>1 OF 2 |
| REVISION DATES | |

**PURPOSE:**

The purpose of this policy is to establish guidelines to follow in the event that a Behavioral Health Centers employee needs to report a suspected violation of the policies and procedures in place to protect patient PHI.

**SCOPE:**

This policy applies to all employees of Behavioral Health Centers.

**RESPONSIBILITY:**

It is the responsibility of the HIM Department to implement these policies and procedures. It is the responsibility of each employee's direct supervisor to disseminate it.

**POLICY:**

It is the policy of Behavioral Health Centers to establish guidelines to follow in the event that a Behavioral Health Centers employee needs to report a suspected violation of the policies and procedures in place to protect patient PHI.

**PROCEDURE:**

Any individual reporting a potential violation of privacy shall be free of retribution. All staff are encouraged to report any potential violations.

**Reporting Behavioral Health Centers Staff**

1. All staff members are required to report possible violations of privacy to their supervisor. If the supervisor determines that a violation occurred, or that the situation warrants further investigation, the possible violation shall be reported to the HIM Department.

| TITLE<br><br>REPORTING SUSPECTED VIOLATIONS OF PRIVACY | POLICY NO.<br><br>IM-1:014 |
|---|---|
| SUBJECT<br><br>INFORMATION MANAGEMENT | PAGE(S)<br><br>2 of 2 |

2. Reportable offenses include any uses and disclosure of patient PHI that may violate their consent or authorization.
    i. Reportable offenses also include any unnecessary discussion of PHI in public areas or in a location where the discussion might result in the disclosure of PHI to unauthorized individuals. Example: Discussing a patient's diagnosis in the lobby of one of the centers.

3. The staff member reporting a violation should describe the possible violation in writing, or should arrange a meeting with the HIM Department to discuss the possible violation.

4. Under the following circumstances, potential violations should not be reported by a staff member to their supervisor:
    i. When the violation involves the staff member's supervisor, it should be reported directly to the HIM Department.
    ii. When the violation involves the HIM Department, it should be reported directly to the Chief Operations Officer or Chief Executive Officer.
    iii. When the violation involves the Chief Administrative Officer or Chief Executive Officer, it should be reported directly to the Secretary of Health and Human Services.

**Reporting Behavioral Health Centers Business Associates**

1. All staff members that are aware of activities or practices by the Business Associate(s) that violate its contractual obligations, it must be reported to the HIM Department.

| TITLE<br><br>STORAGE AND MAINTENANCE OF RECORDS | NUMBER<br><br>IM-1:016 |
|---|---|
| SUBJECT<br><br>INFORMATION MANAGEMENT | EFFECTIVE DATE<br><br>07/01/2017 |
| REVIEW DATES | PAGE(S)<br><br>1 OF 2 |
| REVISION DATES | |

**PURPOSE:**

The purpose of this policy is to outline the process of the storage and maintenance of patient protected health information.

**SCOPE:**

This policy applies to the Chief Executive Officer in conjunction with the Compliance and Health Information Management departments of Behavioral Health Centers and affiliates.

**RESPONSIBILTY:**

It is the responsibility of the Chief Executive Officer in conjunction with the Compliance and Health Information Management departments to implement this policy and procedure.

**POLICY:**

It is the policy of Behavioral Health Centers and affiliates to provide secure storage and maintenance for patient protected health information.

**PROCEDURE:**

**RETENTION AND DISPOSAL OF MEDICAL RECORDS:**

Behavioral Health Centers and affiliates stores their paper medical records off site in a secure storage facility. When a request for these medical records is made additional time *may* be required to meet the patient's request. If additional time is needed, the patient must be notified any delays in providing protected health information.

Storage and maintenance of patient protected health information is provided in 2 ways:

1. Off-Site at a secure storage facility

| TITLE | NUMBER |
|---|---|
| STORAGE AND MAINTENANCE OF RECORDS | IM-1:016 |
| SUBJECT | PAGE(S) |
| INFORMATION MANAGEMENT | 2 OF 2 |

2. Electronically:
    a. TIER electronic medical record
    b. Encrypted Backup at Secure Data Center
3. Any paper medical records stored on site must be secured behind two access points.
    a. For example: Secured file cabinet behind a locked door.
4. The only personnel that are to maintain keys for the secure area are the CEO and the Director of Health Information Management.
5. All records shall be retained for a minimum of seven (7) years.
6. All records disposed of will be shredded to ensure that no possible disclosure of information can occur.
7. Behavioral Health Centers and affiliates shall maintain a record of all patient records destroyed, including the patient name, record number, birthday, and dates of admission and discharge.