SAINT LOUIS UNIVERSITY

COPYING AND PRINTING PHI

Policy Number: OUC-035 **Version Number: 2.0**
Effective Date: 04/14/2003
Responsible University Official: Privacy Officer
Approved By: Executive Staff
Legal and Compliance Committee

1.0 INTRODUCTION

Saint Louis University (hereinafter the "University") is committed to provide services in compliance with all state and federal laws governing its operations, incorporating the highest levels of business and professional ethics. The Privacy Rule requires covered entities to take reasonable steps to limit the use or disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose. Limiting of copying and printing of PHI is appropriate for protecting patient privacy and safeguarding of PHI.

2.0 PURPOSE

The purpose of this policy is to ensure patient confidentially by limiting the copying of medical information and use of printed information only when it is essential to patient care, release of information, payment, or operational purposes. Copying and printing of protected health information should be in accordance with the minimum necessary standard.

3.0 PERSONNEL AFFECTED

This policy applies to all regular full-time and part-time faculty and staff and volunteers within all divisions of the University, including employees, professional staff members, residents, agents, representatives and consultants with access to patients' protected health information.

4.0 DEFINITIONS

Minimum Necessary Standard: The requirements outlined in the HIPAA Privacy Regulations that mandates use of reasonable measures to limit the use and disclosure of PHI to that which is needed in performing necessary functions for treatment, payment or health care operations.

Protected Health Information (PHI): Any individually identifiable health information transmitted or maintained in any form or medium, including oral, written, and electronic. Individually identifiable health information relates to an individual's health status or condition, furnishing health services to an individual or paying or administering health

care benefits to an individual. Information is considered PHI where there is a reasonable basis to believe the information can be used to identify an individual.

Workforce: Employees, volunteers, trainees, contractors, and other persons under the direct control of the covered entity, whether or not paid by the covered entity, who have access to confidential information.

5.0 POLICY

All University personnel must strictly observe the following standards relating to the printing and copying of PHI:

- Protected health information in hardcopy format must be disposed of in accordance with the *Disposal of PHI* policy.
- Printed versions of PHI should not be copied indiscriminately or left unattended and open to compromise.
- Printers and copiers used for printing of PHI should be in a secure, non-public location. If the equipment is in a public location, the information being printed or copied must be strictly monitored.
- PHI printed to a shared printer should be promptly removed.
- Media and hardcopy containing PHI must have access controls during transportation and disposal, see *Disposal of PHI* policy.

6.0 SANCTIONS

Individuals who fail to comply with this policy and the procedures associated with it will be subject to disciplinary actions guided by the University's Staff Performance Management Policy, Faculty Manual, or Student Guidelines.

Non-compliance in this Policy can result in disciplinary action, including but not limited to, restricted incentive payments, suspension or termination. It may also result in the enforcement of a corrective action plan, as well as notification of the suspected misconduct and/or violation to government regulatory agencies.

This Policy does not limit the University’s ability to impose greater sanctions or impose immediate action against serious violations. Disciplinary actions appropriate to the severity of the infraction will be carried out as needed.

7.0 CHANGES TO THIS POLICY

Changes to this policy may be necessary from time to time. At a minimum, the policy and all other program policies, procedures and guidelines will be reviewed on an annual basis.

8.0 RELATED POLICY AND DOCUMENTS

- Disposal of Protected Health Information
- Minimum Necessary Disclosure

REVISION HISTORY

EFFECTIVE DATE	VERSION NUMBER	MODIFICATION
4/14/2003	1.0	New Policy
7/01/2008	1.1	Review & Format Change
3/01/2015	1.2	Review & Format Change
	2.0	Ownership Shifted from Provost to General Counsel