SAINT LOUIS UNIVERSITY

MINIMUM NECESSARY DISCLOSURE

Policy Number: OUC-041 **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 HIPAA Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose. The minimum necessary standard does not apply to all circumstances. The University will ensure that the appropriate steps are taken to disclose only the minimum amount of PHI necessary to accomplish the particular use or disclosure, as required by HIPAA regulation, and other applicable federal, state, and/or local laws and regulations.

2.0 PURPOSE

The purpose of this policy is to outline processes for HIPAA regulation 164.502 which requires that reasonable efforts are made not to disclose more than the minimum amount of protected health information (PHI) necessary to accomplish the intended purpose of the use, disclosure, or request within the constraints of practical and technical limitations.

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

Authorization: A document that gives permission for a specific disclosure of protected health information. Authorizations typically include the name of the person or entity authorized to disclose, name of the person or entity authorized for use or disclosure, purpose of the disclosure, expiration of the authorization, and the patient's signature.

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.

5.0 POLICY

1. Saint Louis University workforce will follow proper procedures to ensure that only the minimum amount of patient health information necessary to accomplish the specific purpose of a use or a disclosure is actually used or disclosed.

2. All proposed releases of PHI will be reviewed by appropriate workforce having an understanding of the University's privacy policies and procedures for reviewing authorizations of disclosure.

3. Use or disclosure of an entire medical record will only occur when specifically justified as being reasonably necessary to accomplish the purpose of the use, disclosure, or request.

4. Saint Louis University workforce will maintain appropriate levels of access to PHI necessary to accomplish their routine duties and responsibilities. Availability to protected health information will be reasonably limited through utilization of access controls.

5. The following criteria will be used in limiting the amount of protected health information requested, used, or disclosed by University personnel:
    a. Does the requesting individual have complete understanding of the purpose for the request, use, or disclosure of the protected health information?
    b. Are all of the individuals identified for whom the use or disclosure of the protected health information is required?

6. Requests for releases of information will be reviewed on an individual basis in accordance with University policies and procedures.

7. University personnel may reasonably rely on requests by:
    a. Public health and law enforcement agencies in determining the minimum necessary information for certain disclosures;
    b. Other covered entities in determining the minimum necessary information for certain disclosures; or
    c. By a professional who is a member of its workforce or is a business associate of the University for the purpose of providing professional services to the University, if the professional represents that the information requested is the minimum necessary for the stated purpose.

8. In the event of disclosures for research purposes, the University will review the documentation required of the Institutional Review Board in determining minimum necessary for stated purpose.

9. Requests for releases of information will be reviewed on an individual basis in accordance with University policies and procedures.

10. This policy does not apply to the following uses or disclosures:

    a. Disclosure to or request by a provider for purposes of treatment;
    b. Uses or disclosure made to the individual who is the subject of the information ;
    c. Uses or disclosure pursuant to an authorization;
    d. Uses or disclosures required by law;
    e. Uses or disclosure required for compliance with applicable laws and regulations.

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 POLICIES & DOCUMENTS

- Authorization for Use or Disclosure Policy
- Authorization for Use and Disclosure of Psychotherapy Notes Policy
- Authorization for Disclosure (Form)
- Authorization to Use or Disclose Patient Image (Form)

REVISION HISTORY

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