

PRIVACY 24.0 OVERVIEW OF THE USES AND DISCLOSURES OF PHI

Scope: All **workforce** members (employees and non-employees), including employed medical staff, management, and others who have direct or indirect **access** to patient **protected health information (PHI)** created, held or maintained by any subsidiaries of Universal Health Services, Inc., including facilities and UHS of Delaware Inc. (collectively, “UHS”), including UHS covered entities (“Facilities”).

Purpose: To provide an overview of permissible **uses** and **disclosures** of **PHI** and to cross reference applicable UHS privacy policies addressing **uses** and **disclosures** in these situations.

Definitions:

Terms not defined in this Policy or the *HIPAA Terms and Definitions* maintained by the UHS Compliance Office will have the meaning as defined in any related State or Federal privacy law including the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (“HHS”) at 45 CFR Part 160 and 164, Subparts A and E (“Privacy Regulations” or “Privacy Rule”) and Subparts A and C (“Security Regulations” or “Security Rule”), the Health Information Technology for Economic and Clinical Health Act (“HITECH”) privacy and security provisions of the American Recovery and Reinvestment Act (Stimulus Act) for Long Term Care, Public Law 111-5, the American Recovery and Reinvestment Act of 2009 (“ARRA”), Title XIII and related regulations.

Policy:

PHI will not be **used** or **disclosed** by Facility **workforce** members except as permitted or required by **HIPAA** and applicable state laws. Whenever required by the **Privacy Rule**, the **workforce** member will make reasonable efforts to limit the **use** and **disclosure** of **PHI** to the **minimum necessary** to accomplish the intended purpose of the **use**, **disclosure** or request. Each Facility must reasonably safeguard **PHI**: (i) from any intentional or unintentional use or disclosure that violates UHS or Facility HIPAA policies, and (ii) to limit **incidental** uses or disclosures. State law may impose additional requirements on the **use** and **disclosure** of **PHI** – Facilities will contact the UHS Legal Department if they have any questions regarding the state laws applicable to them.

Procedure:

This Policy discusses the use and disclosure of **PHI**, addressed in sections as follows:

- Permitted Uses and Disclosures
- Required disclosures

- Minimum necessary applies
- Safeguards
- Uses and disclosures subject to an agreed-upon restriction
- Uses and disclosures of de-identified PHI, and to create de-identified PHI
- Disclosure to business associates
- Deceased Individuals
- Personal representatives
- Confidential communications
- Uses and disclosures consistent with the Notice of Privacy Practices
- Disposal of PHI
- State Laws

Permitted Uses and Disclosures

PHI may not be **used** or **disclosed** except as permitted or required by **HIPAA** and applicable state law. **PHI** may be **used** or **disclosed** as follows:

- To the patient (or their authorized personal representative, as applicable) (the “individual”);
- For **treatment, payment, or health care operations**, as described in UHS Privacy 5.0 *Use and Disclosure for Treatment, Payment and Health Care Operations*.
- **Incidental uses or disclosures** that occur as a byproduct of a permissible or required **use or disclosure**, as long as the Facility has applied reasonable safeguards and implemented the minimum necessary standard, where applicable, for the primary **use or disclosure**.
- Pursuant to and in compliance with a valid authorization from the individual under the UHS HIPAA policy *Use and Disclosure Requiring Authorization*.
- Pursuant to an agreement under or as otherwise permitted by UHS Privacy 25.0 *Uses and Disclosure Requiring an Opportunity to Agree/Object* -- including, subject to that Policy, **uses and disclosures**:
 - for facility directories;
 - to persons involved in a patient’s care or payment;
 - for notification;
 - for disaster relief; and

- to a family member or other persons involved in the care or payment for care of a deceased patient prior to death (limited to the PHI of a deceased individual that is relevant to such person's involvement) unless the disclosure would be inconsistent with any prior expressed preference of the individual that is known to the Facility.
- As permitted by and in compliance with UHS Privacy 26.0 *Use and Disclosure Not Requiring Authorization or an Opportunity to Agree/Object*. These include, subject to that Policy, [uses](#) and [disclosures](#):
 - for public health activities;
 - for health oversight activities;
 - required by law;
 - about immunizations of a student or prospective student to their school;
 - about victims of abuse, neglect or domestic violence;
 - for judicial and administrative proceedings;
 - for law enforcement purposes;
 - to avert a serious threat to health and safety;
 - about decedents;
 - for cadaveric organ, eye or tissue donation;
 - for research purposes;
 - for specialized government functions; and
 - for workers compensation.
- As permitted by and in compliance with UHS Privacy 7.0 *Limited Data Sets and Data Use Agreements*.

Required Disclosures

Facilities are required to [disclose PHI](#):

- To an individual upon request and subject to UHS Privacy 19.0 *Patient Requests to Access PHI*;

- For an accounting of **disclosures** of **PHI** provided to an individual upon request and subject to the UHS HIPAA policy *Accounting of Disclosures*;
- When required by the Secretary of Health and Human Services (HHS) to determine the Facility's HIPAA compliance.

Minimum Necessary Applies

When using or **disclosing PHI** or when requesting **PHI** from another covered entity or a business associate, a Facility must make reasonable efforts to limit **PHI** to the minimum necessary to accomplish the intended purpose of the **use, disclosure,** or request, as described in the UHS HIPAA *Minimum Necessary Policy*.

Safeguards

Each Facility must reasonably safeguard **PHI**: (i) from any intentional or unintentional **use** or **disclosure** that violates UHS or Facility HIPAA policies, and (ii) in order to limit **incidental uses** or **disclosures**.

Uses and Disclosures of PHI Subject to an Agreed-Upon Restriction

A Facility that has agreed to a restriction under UHS Privacy 21.0 *Patient Requests for Disclosure Restrictions or for Alternative Communications* may not **use** or **disclose** the **PHI** covered by the restriction in any manner that would violate the restriction, unless an exception applies as addressed in the policy.

Uses and Disclosures of De-Identified PHI and to Create De-Identified PHI

A Facility may **use PHI** to create **de-identified PHI** or may **disclose PHI** only to a **business associate** for **de-identification**. Health information that meets the standard and implementation specifications for **de-identification** as described in UHS Privacy 8.0 *De-Identification of PHI* is not considered to be **PHI** and can therefore be **used** or **disclosed** for any lawful purpose, as long as:

- if a code or other identification is **used** to enable re-identification or for any other purpose does not constitute **PHI**; and
- the **de-identified** information is not re-identified.

Disclosures to Business Associates

A Facility may **disclose PHI** to a **business associate** and may allow a **business associate** to create or receive **PHI** on its behalf, if the Facility obtains satisfactory assurance that the **business**

associate will appropriately safeguard the information and enters into a *business associate agreement*, as described in UHS Privacy 27.0 *Business Associates and Business Associate Agreements*. The minimum necessary standards in UHS Privacy 6.0 *Minimum Necessary Policy* apply to disclosures to business associates.

Deceased Individuals

A Facility must comply with the same *use* and *disclosure* requirements described in this Policy with respect to the *PHI* of a deceased individual. If under applicable law an executor, administrator, or other person has authority to act on behalf of a deceased individual or of the individual's estate, a covered entity must treat such person as a personal representative under this subchapter, with respect to *PHI* relevant to such personal representation. Other permitted *uses* and *disclosures* of the *PHI* of deceased individuals are addressed in UHS Privacy 16.0 *Disclosures for Law Enforcement Purposes*, UHS Privacy 25.0 *Use and Disclosure Requiring an Opportunity to Agree/Object*, and UHS Privacy 26.0 *Use and Disclosure not Requiring an Opportunity to Agree/Object*.

Personal Representatives

Except for unemancipated minors and/or abuse, neglect, and endangerment situations, a Facility must treat an authorized *personal representative* as the patient with respect to *PHI* for purposes of HIPAA. An authorized *personal representative* is a person authority with authority under applicable law to act on behalf of a patient in making decisions related to health care. The requirements for personal representatives are described in UHS Privacy 28.0 *Personal Representatives*.

Confidential communications

If a Facility has granted a patient's request that they receive communications of *PHI* from the Facility by alternative means or at alternative locations, the Facility must comply with the applicable requirements of UHS Privacy 21.0 *Patient's Right to Request Use or Disclosure Restrictions and Alternative Communications* in communicating the *PHI*.

Uses and Disclosures Consistent with the Facility's Notice of Privacy Practices

Facilities may not *use* or *disclose PHI* in a manner that is inconsistent with their Notice of Privacy Practice.

Disposal of PHI

Facilities must implement reasonable safeguards, including appropriate *workforce* training on the Facility's disposal policies and procedures, to limit incidental and avoid prohibited *uses* and *disclosures* of *PHI* in connection with the disposal of the information. In determining what is

reasonable, Facilities should consider potential risks to patient privacy, as well as the form, type and amount of PHI to be disposed.

Although no particular disposal method is required by HIPAA, proper disposal methods may include, for example:

- Shredding, burning, pulping, or pulverizing paper records so PHI is rendered essentially unreadable, indecipherable and cannot be reconstructed;
- Maintaining labeled prescription bottles and other PHI-containing material in opaque bags in a secure area and shredding or using another mechanism to destroy the PHI;
- For electronic media: clearing, purging, destroying, and other sanitization methods;
- Maintaining PHI for disposal in a secure area and using a disposal vendor as a business associate to pick up and shred or otherwise destroy PHI;
- Using a business associate to appropriately dispose of PHI on the Facility's behalf

Workforce members may not dispose PHI in a dumpster or other containers accessible by the public without using proper methods of rendering PHI essentially unreadable.

State Laws

State law may impose additional requirements – Facilities will contact the UHS Legal Department if they have any questions regarding the state laws applicable to them.

References:

45 C.F.R. § 164.502

45 C.F.R. § 164.504

45 C.F.R. § 164.506

45 C.F.R. § 164.508

45 C.F.R. § 164.510

45 C.F.R. § 164.512

45 C.F.R. § 164.530(c)

Related UHS Policies:

UHS Privacy 23.0 *Accounting of Disclosures*

UHS Privacy 27.0 *Business Associates and Business Associate Agreements*

UHS Privacy 8.0 *De-Identification of PHI*

UHS Privacy 16.0 *Disclosures for Law Enforcement Purposes*

UHS Privacy 17.0 *Disclosures to Correctional Institutions or Law Enforcement with Lawful Custody*

UHS Privacy 7.0 *Limited Data Sets and Data Use Agreements*

UHS Privacy 6.0 *Minimum Necessary Policy*

UHS Privacy 19.0 *Patient Requests to Access PHI*

UHS Privacy 21.0 *Patient Requests for Use or Disclosure Restrictions or for Alternative Communications*

UHS Privacy 28.0 *Personal Representatives*

UHS Privacy 5.0 *Use and Disclosure for Treatment, Payment and Health Care Operations*

UHS Privacy 14.0 *Use and Disclosure for Research and Reviews Preparatory to Research*

UHS Privacy 9.0 *Disclosure for Armed Services, National Security, and other Specialized Government Functions*

UHS Privacy 26.0 *Use and Disclosure Not Requiring Authorization or an Opportunity to Agree/Object*

UHS Privacy 3.0 *Use and Disclosure Requiring Authorization*

UHS Privacy 25.0 *Use and Disclosure Requiring an Opportunity to Agree/Object*

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Reviewed and Approved by:

UHS Compliance Committee