# HIPAA Center Staff Questions

# Administration

1. **Program Instruction 02-19 states that centers should work toward being in compliance by April 14, 2003, and that the plan should be shared with the Regional Director. When should the plan be in final written form for submission to the Regional Office?**

This is a Regional Office decision as to when they want to review the plans.

1. **Can the Authorization or Notice be faxed to the center?**

Yes. Signed Authorizations and Notices can be faxed to the center.

1. **Can only the signature page of the Authorization and/or Notice be maintained in the student's health record?**

No. A complete Authorization and Notice (All pages, including the signature page) must be maintained in the student's health record.

1. **How often can students request a copy of their protected health information (PHI)? How far back can they request copies of their PHI?**

Neither the Privacy Rule nor any HHS guidance we could locate limits the frequency with which individuals may access or get copies of their PHI. Individuals may request copies of their PHI for as long as the PHI is maintained in the designated record set.

1. **How much time do we have to respond to a request for PHI and does that request have to be received in a particular format?**

You may require individuals to make requests in writing (but you don't have to). If you have such a requirement, you have to tell them about it (instead of just not responding to verbal requests). You have to produce only PHI that is contained in a "designated record set." The "designated record set" is the medical and billing records you maintain (or someone else maintains for you) that you use to make decisions about individuals (like a patient file). You must act on requests within 30 days, with one possible 30-day extension (if you provide a written reason for the delay and a date by which you will act). If the information requested is stored off-site, you have 60 days (plus one extension) to act. You can deny a request in certain circumstances, such as if the access is reasonably likely to endanger the life or physical safety of the individual or another person. You must provide a review process for some denials (see 45 CFR 164.524).

1. **Can a fee be charged for copying PHI when a patient requests a copy of his/her record?**

You may charge a reasonable, cost-based fee. The fee may include only the cost of copying (including supplies and labor) and postage, if the patient requests that the copy be mailed. If the patient has agreed to receive a summary or explanation of his or her PHI in lieu of the actual records, you may also charge a fee for preparation of the summary or explanation. The fee may not include costs associated with searching for and retrieving the requested information.

1. **Can the health and wellness center (HWC) treat/counsel/consult with a minor student prior to having the Notice signed by a parent?**

Yes. In direct treatment relationships, the Privacy Rule requires that the Notice be given to the individual being served at the first visit after April 14, 2003. Job Corps policy requires that the Notice also be sent to parents/guardians of minor students. However, nothing in the Privacy Rule or Job Corps policy requires that parents/guardians be notified of particular treatments or services in states in which that type of parental notification is optional or prohibited. Also, no one should be denied services for lack of a signature. The duty is only to give the Notice to the individual and the parent and ask for a signature. If the recipient of the Notice does not sign, you would document the fact that you provided the Notice and that the person did not sign.

1. **How will we request medical information as a result of the HIPAA process?**

If the medical information is for payment, treatment, or health care operations (PTO), then an Authorization would not be needed. If the information is for other than PTO purposes, and is not covered in the standard Authorization, then the supplemental Authorization must be used.

1. **Some students may resign or risk being separated rather than sign the Authorization. Do you have any guidance on how to avoid or minimize this?**

Under Job Corps policy, the Center Director has discretion in whether to separate a student who refuses to sign. Students should be encouraged to discuss their thoughts on the matter with an appropriate staff person prior to making any decisions. The student's individual circumstances could be explored, and if it appears that the student may be a candidate for continued retention, perhaps the student's resignation might be avoided if that fact is communicated to the student. If the Center Director would separate that student if he or she refused to sign, there is no reason not to tell the student that fact in advance, so he or she could choose to resign instead.

1. **Can patient sign-in sheets still be used?**

Covered entities, such as physician's offices, may use patient sign-in sheets or call out patient names in waiting rooms, as long as the information disclosed is appropriately limited. The HIPAA Privacy Rule explicitly permits incidental disclosures that may result from this practice, for example, when other patients in a waiting room hear the identity of the person whose name is called, or see other patient names on a sign-in sheet. However, these incidental disclosures are permitted only when the covered entity has implemented reasonable safeguards and the minimum necessary standard, where appropriate. For example, the sign-in sheet may not display medical information that is not necessary for the purpose of signing in (e.g., the medical problem for which the patient is seeing the physician). See 45 CFR 164.502(a)(1)(iii).

The definition of "health care operations" in the Privacy Rule provides for "conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers." Covered entities can shape their policies and procedures for minimum necessary uses and disclosures to permit medical trainees access to patients' medical information, including entire medical records.

Covered entities are required to apply the minimum necessary standard to their own requests for protected health information. One covered entity may reasonably rely on another covered entity's request as the minimum necessary, and then does not need to engage in a separate minimum necessary determination. See 45 CFR 164.514(d)(3)(iii). However, if a covered entity does not agree that the amount of information requested by another covered entity is reasonably necessary for the purpose, it is up to both covered entities to negotiate a resolution of the dispute as to the amount of information needed.

1. **Can appointments be announced over loudspeaker?**

This practice is okay provided you (1) announce only the minimum necessary information (e.g., only the names, or names and appointment times, but not anything about the medical condition) and, (2) have a treatment or health care operations reason to make those announcements (e.g., because students do not show up if you notify them in another way). However, if a student asks that you not do that, you should try to honor that request and remind that student in a different way. The closest HHS guidance we could find on this question is the discussion in the previous Q&A about calling out names in a waiting room.

1. **Do parents have to be notified before cursory examinations?**

No, unless required by state law. The Privacy Rule requires that the Notice be given to the individual being treated at the time of first treatment after April 14, 2003, and Job Corps policy requires that parents/guardians of minor students be mailed a copy of the Notice.

1. **Does HIPAA require that facilities be redesigned to provide additional privacy?**

HHS generally does not consider facility redesigns as necessary to meet the reasonableness standard for minimum necessary uses. However, covered entities may need to make certain adjustments to their facilities to minimize access, such as isolating and locking file cabinets or records rooms, or providing additional security, such as passwords, on computers maintaining personal information.

1. **How does HIPAA apply to CIS?**

CIS is available to all or most staff persons on center, so the act of placing information into CIS is the same as telling every center staff person the information. PHI should not be put into CIS unless there is a specific reason that every single staff person needs to know that information and the student has signed a supplemental Authorization allowing it. Even drug test results, which the standard Authorization states may be shared with a wide variety of people, may not be shared with anyone who does not need to know the information. However, information normally kept in employer records may be entered into the CIS and is not PHI. For example, if a student is terminated or suspended due to a failed drug test, or is on a medical leave of absence due to impending birth of a child, that is the type of information any employer might have in order to reasonably manage its facility. Even in these situations, details about any medical condition should not be included.

1. **Will educational materials be developed on the national level for all health and wellness staff, including a written knowledge evaluation (test)?**

Information was sent out in April 2003 to the health and wellness managers and Center Directors. All materials are available on the HIPAA section of this site.

1. **What is/is not appropriate when sending a student's medication to the dorms?**

The Authorization allows information to be shared with residential living staff about medications. Only staff members who need to know in order to assist the student should receive the medication (or information about it), and those staff persons should be told only the minimum necessary information they need to assist the student. (If there is a risk of adverse events occurring due to the student's condition or failure to take medication, the minimum necessary could well include a complete briefing on the condition and/or the medication, depending on the circumstances. The goal is to protect health information consistent with ensuring student health and safety.)

# Authorization/Notice

1. **When an individual reaches the age of majority or becomes emancipated, who controls the protected health information concerning health care services rendered while the individual was an unemancipated minor?**

The individual who is the subject of the protected health information can exercise all rights granted by the HIPAA Privacy Rule with respect to all protected health information about him or her, including information obtained while the individual was an unemancipated minor consistent with State or other law. Generally, the parent would no longer be the personal representative of his or her child once the child reaches the age of majority or becomes emancipated, and therefore, would no longer control the health information about his or her child. Of course, any individual can have a personal representative – which may include a parent – who can exercise rights on his or her behalf.

1. **Students are to have a signed Authorization on file prior to entry, and any student who does not have an Authorization signed should be delayed. What if a student arrives on center without one?**

The Privacy Rule requires an Authorization before the disclosures listed in the Authorization may be made. Job Corps policy makes the Authorization a condition of enrollment. However, in the question posed, somehow the student has been enrolled without one. In that case, the student who is 18 and above should be asked to sign the Authorization on center. If the student refuses, Job Corps policy for students on center is that the Center Director has the discretion to decide if it is feasible to keep the student on center without being able to share the information listed in the Authorization. Depending on the circumstances, the Center Director might wait until there is a need to share information for which an Authorization would be required before making a decision to separate a student. The minor student needs a parent/guardian signature for the Authorization, and the Center Director may decide to keep the student on center to wait for that signature. The only significance of the Authorization is that without one, the HWC cannot share PHI as described in the Authorization (for instance, it could not share drug test results with disciplinary staff). However, in any given student's case, it may be months before there actually is a need to share the information as described in the Authorization. The core responsibility for getting an Authorization prior to sharing that type of PHI lies with the sharer of the PHI. Most likely, that would be the HWC. However, the Center Director probably has an equal or greater interest in making sure the HWC has the capacity to share the PHI described in the Authorization.

1. **Who is responsible for having the Authorization signed if the student arrives on center without one?**

Job Corps requires that admissions counselors (ACs) obtain the Authorization prior to enrollment, but if a student should arrive without an Authorization, the center will have to decide who actually asks the student to sign.

1. **If a student is off center and efforts to obtain authorization and give notice of privacy practices are unsuccessful (example: letter sent by registered mail is not deliverable for some reason and/or the student does not respond to the center's request for signature) is the center in violation of HIPAA regulations or is the center just restricted from sharing the student's health information until authorization is received?**

The Privacy Rule does not require covered entities to have Authorizations. Rather, the Privacy Rule merely prohibits sharing information for which an Authorization would be required, unless you have an Authorization. The Notice does not need to be given until the student makes his or her next visit to the HWC.

1. **Can students selectively revoke their Authorization? For example, a student has a positive pregnancy test, is a non-resident and does not want anyone on center to know.**

Yes. It is up to the Center Director to decide, based on impact to center operations, whether partial revocation should result in student dismissal from the program. In the example given, the selective revocation seems fairly harmless. However, a selective revocation could be much more disruptive if a student revokes his or her Authorization to share drug test results, for example.

1. **Using the same example, can a student revoke consent for a period of time, e.g., the first two trimesters where she may be unlikely to show?**

Yes. The Center Director has the discretion to determine whether that partial revocation should result in student dismissal. In the example given, we suggest that the selective revocation seems harmless and probably should not result in dismissal.

1. **Just before graduating from our program, a student who had extensive dental work at our center wrote us a letter along with his picture, apologizing for missed appointments, but thanking us for his "beautiful smile." He gave the verbal okay for us to frame his picture and hang it in our clinic. Do we have to ask him to sign a supplemental Authorization?**

Unfortunately, yes. (***This is a change*** from what we had believed previously.) We checked this question with HHS, and received a response that we should have an Authorization on file.

1. **If a student continues to be seen by his or her previous health provider while in the program, can that student revoke an authorization he or she signed with that provider to share PHI with the center, if treatments are not affecting or interfering with his/her participation in the program? (The student might feel embarrassment over his or her condition and not want to reveal it, for example.)**

Yes. The Privacy Rule does not require any health provider to share information with the HWC. That is a professional decision that provider would make. The HWC can request information from the previous health provider for treatment purposes (no student agreement is needed), or if the student has signed an Authorization with that provider. The student can ask the provider not to share PHI with the HWC. The provider does not have to agree to that request, and may choose to share information for treatment purposes anyway. If the reason the provider would share PHI with the HWC is because the student signed an authorization with the practitioner, the student may revoke that authorization. After that, the provider would be prohibited from sharing PHI with the HWC.

1. **Is it the national policy of Job Corps not to keep students or let them in the program if they refuse to sign the standard Authorization, or revoke it later? Or will it be on a case-by-case basis?**

It is national Job Corps policy that, as of April 14, 2003, the standard Authorization is a condition of enrollment in Job Corps. Applicants should not be enrolled into Job Corps if they refuse to sign the standard Authorization. If it is not a question of refusal, but the Authorization is simply delayed for some reason, the center should request a delay of departure until the Authorization is received. However, if a student was enrolled already and on center prior to April 14, and now refuses to sign, the Center Director will decide on a case-by-case basis if the student is to stay in the program. Similarly, if an enrolled student on center has signed the Authorization, but then revokes it, or any part of it, this revocation should be communicated to the Center Director. The Center Director will decide on a case-by-case basis if the student is to stay in the program. Some revocations (such as desiring to hide an early pregnancy) may be harmless, while others (such as desiring to hide drug test results) may interfere with center operations.

# Compliance

1. **Will a center be out of compliance if not all signatures are obtained by April 14, 2003?**

HIPAA is effective on April 14, 2003. Health and Wellness staff cannot release any PHI on students who have not signed an Authorization, unless it falls under one of the 14 items listed in the Notice that allows disclosure of PHI without consent.

1. **Can a Regional Office Center Assessment be performed at a center where the Authorizations have not been signed?**

Yes. This is considered Regional Office oversight and is covered by the Notice.

1. **Who will be responsible to enforce HIPAA and address student and staff concerns?**

Centers are to appoint a Privacy Officer responsible for developing and implementing Privacy Rule policies and procedures. Centers also must appoint someone to answer questions and receive complaints. One person could be designated to do both, but conflicts of interest should be avoided.

1. **What are the legal ramifications of staff violating the HIPAA Privacy Rule?**

HHS may impose civil penalties on a covered entity of $100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed $25,000 a year for violations of the same requirement. A person who knowingly obtains or discloses PHI in violation of HIPAA faces a fine of $50,000 and up to one year in jail. If the wrongful conduct involves the intent to sell, transfer, or use PHI for commercial advantage, personal gain, or malicious harm, fines increase up to $250,000 and 10 years in jail.

1. **Are contracted center mental health consultants (CMHCs) "business associates?"**

No. Health care providers are not typically business associates of each other. The CMHC is contracted to provide services to students, not to provide services (such as auditing, accounting, or quality control) to other health care providers or to the HWC. Also, most likely, your management will designate the HWC as an "organized health care arrangement" (OHCA), because it is a single integrated clinical care setting under which a student can obtain a variety of health services. Members of the OHCA, which would include everyone in the HWC (subcontractors, receptionist, HWM, etc.), are not business associates of each other.

1. **Do state laws supercede federal laws?**

The Privacy Rule preempts any state law that conflicts with it, unless that state law is more protective of patient privacy. If a state law protects patient privacy more than the Privacy Rule, you would follow that state law.

1. **Can you provide guidance on minimum information necessary?**

The Privacy Rule states that when "using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request." The Privacy Rule also states that a covered entity must identify the persons (or class of persons) in its workforce who need access to PHI to carry out their duties, and for each person (or class of persons), the categories of PHI to which access is needed and any conditions appropriate to such access. In addition, for routine or recurring disclosures, the entity must implement policies that limit the PHI to the amount reasonably necessary (individual Privacy Rule review of each weekly or monthly report, for example, is not necessary). For other types of disclosures (non-routine), the entity must develop criteria designed to limit the PHI to the amount reasonably necessary and review those requests on an individual basis. Similar policies must be adopted for routine requests for PHI from the entity to others as well as non-routine requests to obtain PHI from others. An entity cannot disclose or request an entire health record unless the entire record "is specifically justified as the amount that is reasonably necessary to accomplish the purpose."

The following guidance comes from various places in the HHS HIPAA FAQs (<http://www.hhs.gov/ocr/hipaa>): "The HIPAA Privacy Rule requires a covered entity to make reasonable efforts to limit use, disclosure of, and requests for protected health information to the minimum necessary to accomplish the intended purpose. To allow covered entities the flexibility to address their unique circumstances, the Privacy Rule requires covered entities to make their own assessment of what protected health information is reasonably necessary for a particular purpose, given the characteristics of their business and workforce, and to implement policies and procedures accordingly. This is not an absolute standard and covered entities need not limit information uses or disclosures to those that are absolutely needed to serve the purpose. Rather, this is a reasonableness standard that calls for an approach consistent with the best practices and guidelines already used by many providers and plans today to limit the unnecessary sharing of medical information.

The minimum necessary standard requires covered entities to evaluate their practices and enhance protections as needed to limit unnecessary or inappropriate access to protected health information. It is intended to reflect and be consistent with, not override, professional judgment and standards. Therefore, it is expected that covered entities will utilize the input of prudent professionals involved in health care activities when developing policies and procedures that appropriately limit access to personal health information without sacrificing the quality of health care.

# Disability

1. **I have a question about the Privacy Rule regarding student consent to release information to other federal or state agencies. In many cases, several agencies may be involved. It is often necessary to share similar information with each agency. I am currently using a separate Disability Coordinator Consent for Release of Information. Should the form be modified to include each agency?**

If you are releasing information to obtain payment or reimbursement for student medications or to obtain treatment or devices for the student, this is covered in the Notice under treatment, payment, and health care operations and you would not need to change your current practices. Also, if the release is required by law for statistical or reporting purposes to a state or federal agency, this is covered by the Notice and you would not need to change your current practices. (Under the Privacy Rule, you would not need any release form at all; however, probably you are using the release forms already for a reason unrelated to the Privacy Rule.) However, if the reason for release of information is not a reason listed in the Notice or the standard Authorization, you would need to ask the student to sign a supplemental Authorization. You can list all the different agencies on one Authorization, as long as you list separately the disclosures for each agency. You should state which agency is getting which information for what purpose, and who is doing the releasing for each agency. This may involve cutting and copying the blanks in the supplemental Authorization form so you have several distinct sections, each covering disclosure to a different agency.

1. **Currently, all disability files originate and are kept in my office. Is this still an acceptable procedure?**

If the files contain PHI, you must establish "reasonable safeguards" to prevent unauthorized disclosure. What is "reasonable" may vary in different circumstances. However, if you currently keep all the disability information in your office, and you have a lock on your office door so you can safeguard the files while you are not in your office, or else you keep the files in a locked cabinet so that you control access to the files, that is probably a reasonable safeguard against unauthorized disclosure.

1. **Are there any guidelines related to how medical and mental health disabilities should be documented in the support plan of the PCDP to be able to reflect the information on goals within the plan while protecting the privacy of the student?**

No PHI can be placed on the PCDP except as listed in the standard Authorization. There are plans to add a field where accommodations can be listed.

# Disclosures

1. **Can the HWC release medical information to recruiters?**

Not without the student signing an Authorization. A sample supplemental Authorization may be of assistance. Keep in mind, however, that health information kept in the regular student records (for instance, about a modification or accommodation for a disability) is not PHI.

1. **Can information be released that was received from a different agency?**

PHI includes information in the health record that was received from other sources, including state or federal agencies. It would be protected in the same way other information in the health record is protected.

1. **Is providing records to law enforcement unethical?**

Nothing in the Privacy Rule requires health care providers to give records to law enforcement. However, the Privacy Rule does permit such disclosures under certain circumstances. You may disclose PHI as required by law, including laws that require the reporting of certain types of wounds or other injuries. You may disclose PHI in response to a court order (including a court subpoena) or a grand jury subpoena. You may disclose PHI in response to an administrative request so long as the information sought is relevant to a legitimate law enforcement inquiry, is limited in scope, and de-identified information could not reasonably be used. There are also certain other permissible disclosures of PHI (relating to identification and location purposes, crime victims, decedents, and crime on the premises).

1. **Can you provide any information on reducing incidental disclosures involving records maintenance?**

Covered entities should also take into account their ability to configure their record systems to allow access to only certain fields, and the practicality of organizing systems to allow this capacity. For example, it may not be reasonable for a small, solo practitioner who has largely a paper-based records system to limit access of employees with certain functions to only limited fields in a patient record, while other employees have access to the complete record. In this case, appropriate training of employees may be sufficient. Alternatively, a hospital with an electronic patient record system may reasonably implement such controls, and therefore, may choose to limit access in this manner to comply with the Privacy Rule.

The physician or other health care professionals use the patient charts for treatment purposes. Incidental disclosures to others that might occur as a result of the charts being left in the box [outside the door] are permitted, if the minimum necessary and reasonable safeguards requirements are met. See 45 CFR 164.502(a)(1)(iii). As the purpose of leaving the chart in the box is to provide the physician with access to the medical information relevant to the examination, the minimum necessary requirement would be satisfied. Examples of measures that could be reasonable and appropriate to safeguard the patient chart in such a situation would be limiting access to certain areas, ensuring that the area is supervised, escorting non-employees in the area, or placing the patient chart in the box with the front cover facing the wall rather than having protected health information about the patient visible to anyone who walks by. Each covered entity must evaluate what measures are reasonable and appropriate in its environment. Covered entities may tailor measures to their particular circumstances. See 45 CFR 164.530(c).

The Privacy Rule explicitly permits certain incidental disclosures that occur as a by-product of an otherwise permitted disclosure for example, the disclosure to other patients in a waiting room of the identity of the person whose name is called. In this case, disclosure of patient names by posting on the wall is permitted by the Privacy Rule, if the use or disclosure is for treatment (for example, to ensure that patient care is provided to the correct individual) or health care operations purposes (for example, as a service for patients and their families). The disclosure of such information to other persons (such as other visitors) that will likely also occur due to the posting is an incidental disclosure.

1. **Do OWCP disclosures have to be documented and included in an Accounting of Disclosures?**

OWCP disclosures do not have to be documented for the Accounting if they fall under payment or health care operations. In the Job Corps system, we understand there are two basic types of reporting involved in OWCP matters. The first is the SHIMS report. SHIMS is not an OWCP disclosure per se; it is a report done for all conditions regardless of whether the condition ultimately results in an OWCP claim. We think the SHIMS reports are included under health care operations, because the purpose of the SHIMS involves things like quality assessment and improvement activities, protocol development, case management and care coordination, and evaluating HWC performance. We asked an HHS attorney about disclosures for OWCP purposes specifically (not the SHIMS reports) and received the following response: "I would think that a disclosure for workers' compensation could fall within payment. If the disclosure was, in fact, for payment or health care operations, I think that it would not have to be included in the accounting... However, I would add one cautionary note. Just because the disclosure could be for payment or health care operations purposes, does not mean that any information disclosed for workers' compensation is for these purposes. Minimum necessary applies to payment and health care operations. If more is disclosed then what is minimally necessary for payment or health care operations, but is permitted by 164.512 [the section that permits OWCP disclosures], this would be a disclosure under 164.512, not 164.506 [the section that covers treatment, payment, and health care operations], and the disclosure would need to be accounted for. If there are cases when a workers' compensation disclosure may sometimes fall within payment or health care operations and sometimes within 164.512, it may be easier to just account for it."

1. **Discuss redisclosure.**

"Redisclosure" is disclosure of information by the person/entity to whom a disclosure was made. For example, if the HWC discloses drug test results to the center standards officer (CSO), and the CSO shares that information with a police officer, the CSO has "redisclosed" the information to the police officer. HHS cannot enforce the Privacy Rule as to persons not covered by it, and so is unable to prevent redisclosure by non-covered persons. Because patients typically have a choice whether to agree to an Authorization, the Privacy Rule requires that all Authorizations include a statement about the possibility that the PHI recipient described might further share that information with others (the Privacy Rule would no longer protect that information).

# Electronic Information Transmission

1. **What are the guidelines from the National Office of Job Corps on e-mail - both inter and intra?**

There is nothing unique about e-mail in the Privacy Rule. Entities must have reasonable safeguards to make sure that information is not available to people who do not need it, and to communicate only the minimum necessary information in most cases. Health providers and other health and wellness staff may communicate with students and with each other via e-mail, so long as reasonable safeguards are in place. This could include password-protected e-mail accounts, or having a policy of never hitting the "Reply All" button unless necessary. However, HHS has published Electronic Security Standards with which covered health care providers must comply by April 20, 2005. These standards require things such as passwords, firewalls, and virus protection on computers. These standards are located at the beginning of 45 CFR Part 164.

# Mental Health

1. **Should the CMHC documents be kept separately?**

The only piece of mental health information afforded the added protection of a separate authorization are "psychotherapy notes." These notes are only the provider's own notes of conversations with the patient. This does not include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes are a very narrow category of information. HHS has clarified the treatment of psychotherapy notes as follows: if the psychotherapy notes are not separated from the medical record, they are not psychotherapy notes. It is a condition of the added protection. Separate does not necessarily mean in a separate locked filing cabinet. HHS thinks that probably a separate folder behind the patient's medical record would be fine to meet the "separate" standard and afford greater protection to those notes. However, as stated, no one is required by the Privacy Rule to keep any notes separate; if notes are kept with the regular record they are, by definition, not psychotherapy notes. This means also that the patient could examine them along with the rest of the medical folder unless a basis for denial exists.

1. **Can we request psychotherapy notes from other providers? What happens if the provider does not furnish them?**

Nothing in the Privacy Rule prevents centers from requesting psychotherapy notes from other providers, although requests should be limited to the minimum information necessary. However, nothing in the Privacy Rule requires other providers to give you information. If they were so inclined to give out psychotherapy notes, assuming they are covered under the Privacy Rule they would need a separate authorization from the patient in order to give you psychotherapy notes. We understand that most doctors do not give out the actual psychotherapy notes, in any event. HHS has the following guidance: "Covered entities are required to apply the minimum necessary standard to their own requests for protected health information. One covered entity may reasonably rely on another covered entitys request as the minimum necessary, and then does not need to engage in a separate minimum necessary determination. See 45 CFR 164.514(d)(3)(iii). However, if a covered entity does not agree that the amount of information requested by another covered entity is reasonably necessary for the purpose, it is up to both covered entities to negotiate a resolution of the dispute as to the amount of information needed."

1. **Are there new charting procedures and record keeping procedures for mental health under HIPAA?**

The Privacy Rule does not change recordkeeping procedures for mental health records. However, under the Privacy Rule, psychotherapy notes that are kept separate from the regular health record get added protection. For instance, the student is not entitled to access these notes if he or she asks to review the record. If psychotherapy notes are kept with the regular health record, they are treated the same as any other piece of PHI and would be accessible to the student.

1. **Must the CMHC be notified if someone requests the center's mental health records?**

There is nothing in the Privacy Rule that indicates the CMHC should be notified if someone requests mental health records on a student. This would be a center policy decision. In general, however, the Privacy Rule requires that occasional disclosures of any PHI be limited to the minimum necessary disclosure, and such responses to requests be reviewed by someone before they are sent out to make sure the disclosure is the minimum necessary.

1. **How will HIPAA impact the operations of the CMHC within the Job Corps setting?**

All PHI, including mental health information, may be disclosed only in compliance with the Privacy Rule. CMHCs will operate under the same procedures as other center health professionals. The only thing unique about mental health information is that if psychotherapy notes (the notes of the actual conversations between the mental health professional and the patient) are kept separately from the rest of the health record, they get added protection. For instance, you do not have to give them to the student if he or she asks for a copy of his or her PHI. However, the Privacy Rule does not require you to keep these notes separate, and if you do not keep them separate, they are as accessible as other PHI.

1. **Does the six-year retention requirement apply to psychotherapy/process notes?**

Not unless there has been a disclosure of those notes (and even then, most disclosure do not need to be documented or retained). The Privacy Rule does not require a certain retention period for the contents of the health records or for psychotherapy notes. (Note: if psychotherapy notes are included with the rest of the file, the Privacy Rule does not define them as psychotherapy notes.) Students who ask to see or get a copy of their PHI are entitled only to the contents of the "designated record set," which is the set of records that is being used to treat the student (the health record) at the time. Nothing requires you to keep all pieces of medical information about a student for six years so that the student can access it; the student is entitled only to whatever is in the health record (or any other file you keep on the student in order to treat him or her). However, the Privacy Rule does require that certain disclosures that would be included in an Accounting of Disclosures be retained for six years. Unless there has been a disclosure of those notes, there are no retention requirements. If there was a disclosure of those notes, that disclosure still does not need to be documented if it was for treatment, payment, and health care operations purposes (and other purposes probably not relevant here, such as national security), or if you had an Authorization for the disclosure. However, if the disclosure was to law enforcement, or to a federal/state/local health authority, or in response to a subpoena, among other certain disclosures, you would document that disclosure and retain the disclosure for six years. However, there are state laws that require the retaining of mental health files for a minimum number of years regardless of whether there is disclosure. You must comply with these state laws. Also, keep in mind that if a state law requires or recommends only one file into which psychotherapy notes would be placed along with other medical records, there are no psychotherapy notes. The Privacy Rule does not require that psychotherapy notes be kept separate; if they are not kept separate, they simply cease to be psychotherapy notes under the Privacy Rule.

1. **Does the Privacy Rule permit disclosures that include sharing mental health information between centers about a student that may be transferred?**

Yes, assuming the disclosure is for treatment, payment, or health care operations, or is authorized by the student under a signed Authorization. If a disclosure is made for treatment, payment, or health care operations, it does not need to be documented, and is allowed without student authorization under the Notice. So if one center mental health provider shares student mental health information with another center mental health provider so the student can be appropriately treated and follow-up care can be provided, there is no problem. If the HWC or the center mental health provider is sharing student mental health information for some other purpose, however, then the disclosure should be for a purpose authorized by the Authorization. Disclosures in accordance with the student's Authorization also do not need to be documented. If the purpose for sharing is not listed in the Authorization, the CMHC or the HWC would need to ask for a supplemental Authorization signed by the student. That supplemental Authorization would be voluntary, unless the center gets Regional approval to make it a mandatory condition of participation in the program (like the standard Authorization). You do not need to document disclosures authorized by any authorization (supplemental or otherwise). However, we cannot think of a reason why this information would be disclosed for reasons other than treatment, payment or health care operations, or for a reason not already authorized by the standard Authorization.

# Outreach and Admissions

1. **On the first line of the Authorization, the receiving HWC is identified. What do we do if the applicant is reassigned to another center?**

The applicant must return to the ACs office and initial the change or sign a new Authorization that lists the correct HWC.

1. **Who is responsible for having a Job Corps applicant sign the Authorization if the student is not currently on center, but has a file?**

This depends on where the file is held. If the file is currently with Outreach and Admissions, the responsibility lies with them. If the student file is on center, then the center is responsible for obtaining a signed Authorization.

1. **Can the parent sign the Notice at the AC's office?**

The Notice needs to be specific to the practices of each individual center, and centers should be modifying the prototype Notice accordingly. The Notice will be given by the covered entity at the time of the student’s first visit.

1. **Who is responsible for having the Authorization signed if the student arrives on center prior to the signed Authorization?**

Job Corps requires that the ACs obtain the Authorization prior to enrollment, but if for whatever reason a student arrives without an Authorization, the center will have to decide who actually asks the student to sign.

1. **Should ACs send out for signature supplemental authorizations with blanks?**

The student should never be asked to sign an Authorization that has blanks in it. The ACs could provide a supplemental Authorization to the provider (which would be signed by the student after it is filled in completely); however, we understand that at this point, most providers have their own authorization forms.

# Records Management

1. **Can you provide any information on reducing incidental disclosures involving records maintenance?**

Covered entities should take into account their ability to configure their record systems to allow access to only certain fields, and the practicality of organizing systems to allow this capacity. For example, it may not be reasonable for a small, solo practitioner who has largely a paper-based records system to limit access of employees with certain functions to only limited fields in a patient record, while other employees have access to the complete record. In this case, appropriate training of employees may be sufficient. Alternatively, a hospital with an electronic patient record system may reasonably implement such controls, and therefore, may choose to limit access in this manner to comply with the Privacy Rule.

The physician or other health care professionals use the patient charts for treatment purposes. Incidental disclosures to others that might occur as a result of the charts being left in the box [outside the door] are permitted, if the minimum necessary and reasonable safeguards requirements are met. See 45 CFR 164.502(a)(1)(iii). As the purpose of leaving the chart in the box is to provide the physician with access to the medical information relevant to the examination, the minimum necessary requirement would be satisfied. Examples of measures that could be reasonable and appropriate to safeguard the patient chart in such a situation would be limiting access to certain areas, ensuring that the area is supervised, escorting non-employees in the area, or placing the patient chart in the box with the front cover facing the wall rather than having protected health information about the patient visible to anyone who walks by. Each covered entity must evaluate what measures are reasonable and appropriate in its environment. Covered entities may tailor measures to their particular circumstances. See 45 CFR 164.530(c).

The Privacy Rule explicitly permits certain incidental disclosures that occur as a by-product of an otherwise permitted disclosure for example, the disclosure to other patients in a waiting room of the identity of the person whose name is called. In this case, disclosure of patient names by posting on the wall is permitted by the Privacy Rule, if the use or disclosure is for treatment (for example, to ensure that patient care is provided to the correct individual) or health care operations purposes (for example, as a service for patients and their families). The disclosure of such information to other persons (such as other visitors) that will likely also occur due to the posting is an incidental disclosure.

# TEAP

1. **If a student has a positive 45-day drug test and does not have a signed Authorization, does the student have to be separated as "Withdraw HIPAA consent," or as 05.2A "Drugs (Positive Test, Mandatory)?"**  
   Students who test positive after 45 days for drugs and/or alcohol and have not signed the Authorization have to be separated administratively "Withdraw HIPAA Consent" as opposed to going through the disciplinary system "05.2A Drugs (Positive Test, Mandatory), because we cannot share the student's health information.
2. **Can you reveal urine toxicology screens to center standard officer for zero tolerance?**  
     
   The standard Authorization allows disclosure of drug screen results (including information about alcohol abuse) to the CSO. To reveal this information, the student must have signed the standard Authorization.
3. **Does the Trainee Employee Assistance Program (TEAP) specialist have access to the entire chart as we have allowed in the past?**  
     
   No, unless you have a documented good reason for allowing this complete access. The Privacy Rule states that the "entire medical record" may not be used or disclosed "except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose."
4. **With HIPAA, does the student have the right and must we allow access to the referral for AOD suspicious testing? This would allow the student to see which staff sent in the referral. Some centers keep the staff person's identity anonymous.**  
     
   No. A student is entitled to see only "protected health information" that is kept in a "designated record set" (like the health record). We think there are several different reasons why that staff name need not be released to the student. First, a referral, by itself, might not constitute "health information" and that, in any case, the name of the staff person doing the referring is not PHI. Second, the name of the referring party is not a piece of information that is necessary to treat the student, and so there is no reason to include the name of the referring party in the student's medical folder. If you keep the staff person's name out of the "designated record set," and are not using the name itself for treatment decisions, you do not need to make that name available to the student. Third, even if the referral (including the name) is in the designated record set, and even if it is PHI, it probably would be "information compiled in reasonable anticipation of, or for use in, an administrative action or proceeding" and you would not need to give the student access to it. At many centers the referral for testing upon suspicion is placed in the health record, and may contain PHI, such as information about mental status e.g., slurred speech, unsteady gait, drowsy appearance, etc. Since suspicious AOD testing is conducted for purposes of possible disciplinary action, we think this referral constitutes information compiled "in reasonable anticipation of, or for use in, an administrative action or proceeding" and you would not need to give the student access to any part of the referral. Alternatively, if you chose to give the student access to the referral form, but wanted to keep the name confidential, you could redact the name of the referring party from the referral form when you give the student access to his or her file. We believe the name itself is not PHI and need not be shared with the student.