I. PURPOSE

To establish a policy to ensure Rowan’s School of Osteopathic Medicine (RowanSOM) compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and Omnibus Privacy Final Rule of 2013 in providing an individual the right to restrict uses and disclosures of Protected Health Information (PHI).

II. ACCOUNTABILITY

Under the direction of the President, the Dean, Executive Vice President for Academic and Clinical Affairs, General Counsel, Chief Compliance and Privacy Officer, Vice President for Research shall ensure compliance with this policy.

III. APPLICABILITY

This policy shall apply to health information that is generated during provisions of health care to patients in any of the RowanSOM’s patient care units, patient care centers or faculty practices as well as Human Subjects research under the auspices of the University or by any of its agents in all RowanSOM, Departments and RowanSOM owned or operated facilities.

III. DEFINITIONS

A. Protected Health Information (PHI): Protected health information means individually identifiable health information that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual and identifies or could reasonably be used to identify the individual. The PHI of an individual patient, who has been deceased for more than 50 years, will not be protected [164.502(f)].

1. Except as provided in paragraph two (2) of this definition that is: a) transmitted by electronic media; b) maintained in electronic media; or c) transmitted or maintained in any other form or medium.

B. Designated record set - Medical or billing records about individuals maintained by or for a healthcare provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or records used in whole or in part by or for the provider to make decisions about individuals.

IV. REFERENCES

A. Code of Federal Regulations Title 45, Section 164, Part 522, Right to Request Privacy Protection for Protected Health Information

B. Uses and Disclosures of Health Information
   With and Without an Authorization

The following policies provide additional and related information:

C. Standards for Privacy of Individually Identifiable Health Information

D. Access of Individuals to Health Information

V. POLICY

A. Requirements:

1. Units must permit an individual to request that it restrict:
   - uses and disclosures of PHI about the individual to carry out treatment, payment or health care operations (TPO) for which the individual patient, family member or other person has paid out of pocket in full and including follow-up care associated with the restricted service [164.522(a)(1)(vi)]; and
   - disclosures related to involvement in an individual’s care.

   The Request for Restriction of Health Information form can be accessed at the following website: https://www.rowan.edu/compliance

2. Units may, however, deny the request and document the rational.

3. All requests for restrictions and termination of the agreement to restrict must be in writing.

4. All requests made for restrictions to PHI must be made to the individual designated by the Dean and Chief Compliance and Privacy Officer.

B. Responsibilities:

1. RowanSOM must review all requests that are made by individuals to restrict use and disclosure of the individuals PHI; however, RowanSOM is not required to agree to the restrictions requested if RowanSOM determines that the restrictions would interfere with legitimate treatment, payment or health care operations. The CE must have Minimum Necessary policies and procedures in place, which requires limiting PHI disclosed to a health plan to achieve the purpose of disclosure.

2. If a unit agrees to an individual’s restriction request, the restriction must be appropriately documented and such documentation be retained. Also, the restriction must be communicated in a manner as to assure that anyone accessing the information becomes aware of the restriction. For example, clearly indicate the restriction on the face of the chart or somewhere obvious to anyone accessing the chart.
3. If a unit agrees to an individual’s restriction request, RowanSOM is not permitted to use or disclose the specified PHI, in any manner, except in the event that the individual is in need to emergency treatment and the restricted PHI is needed to provide such treatment. In this case, the unit may use the restricted PHI or disclose the PHI to a healthcare provider to provide such treatment to the individual. In this event, RowanSOM must request that such health care provider not further use or disclose the information. It is the responsibility of the provider to counsel individual patient to get additional restrictions with “downstream” providers that may involve their services.

4. A unit may terminate its agreement to a restriction if:
   - the individual agrees to or requested the termination in writing;
   - the individual orally agrees to the termination and the oral agreement is documented; or
   - the unit informs the individual that it is terminating its agreement to restriction.

5. In the event that a unit, for any of the above mentioned reasons, terminates the agreement to restriction, the termination is only effective with respect to PHI created or received after it has so informed the individual.

By Direction of the President:

**Signature on file**

Chief Compliance & Privacy Officer