ADAMHS BOARD FOR MONTGOMERY COUNTY		BP # 514	
TITLE:	**Member's/client's Right to Request Restrictions on Use/Disclosure of Protected Health Information**	**SUBJECT**	
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PURPOSE: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) granted individuals the right to receive adequate notice of the uses and disclosures of their protected health information (PHI) that may be made by a covered entity, and the individual's rights and the entity's legal duties with respect to PHI. This policy has been developed to assist the Alcohol, Drug Addiction and Mental Health Services Board for Montgomery County to comply with the law and to guide Alcohol, Drug Addiction and Mental Health Services Board for Montgomery County staff in assisting member/clients to exercise their rights.

POLICY:

1. The Alcohol, Drug Addiction and Mental Health Services Board for Montgomery County shall establish and maintain policy and procedure to assure that member/clients shall have the right to request restrictions on how the organization will use or disclosure their protected health information for treatment, payment or health care operations and how their information will be disclosed or not disclosed to family members or others involved in their care.

2. The Alcohol, Drug Addiction and Mental Health Services Board for Montgomery County may, at its discretion, refuse to agree to restrictions on the use of PHI requested by the member/client.

DEFINITIONS

1.1 Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is comprehensive law enacted by the United States government. The law has several subparts providing such benefits as guaranteed portability and renewal of insurance benefits between employers, tax provisions for medical savings accounts and administrative simplification to improve the efficiency and effectiveness of the health care system. During the latter part of the 1990's, the Secretary of the Department of Health and Human Services drafted regulations for standardizing the electronic interchange of administrative and financial data and protecting the security and privacy of personal health information. HIPAA requires health care providers, health plans and health care clearinghouses to transition to the use of standard code sets and "electronic data interchange (EDI) and to maintain reasonable and

appropriate administrative, technical, and physical safeguards to insure the integrity and confidentiality of healthcare information; to protect against reasonably foreseeable threats and hazards to the security or integrity of the information; and, to protect against unauthorized uses or disclosure of the information. Compliance with the first of the HIPAA rules is scheduled for early 2003. HIPAA also provides criminal penalties for failure to comply with the regulations.

1.2 Individually Identifiable Health Information (IIHI). A subset of health information, including demographic information collected from an individual and that is created or received by a health care provider and relates to the past, present, or future physical or behavioral 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 which identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

1.3 Protected Health Information (PHI). The final rule defines PHI as individually identifiable health information that is transmitted by electronic media; maintained in any electronic medium such as magnetic tape, disc, optical file; or transmitted or maintained in any other form or medium (i.e. paper, voice, Internet, fax etc.).

1.4 Treatment, Payment, Health Care Operations (TPO). A healthcare provider, health plan or healthcare clearinghouse may use and disclose PHI (with certain limitations) within and outside the organization for client/member treatment, to facilitate the payment of the client's bills, and for business and clinical operations of the organization. The following definitions apply:

Treatment: provision, coordination or management of health care (care, services or supplies related to the health of an individual) and related services by or among providers, providers and third parties, and referrals from one provider to another provider.

Payment: activities undertaken by a health plan to obtain premiums or determine responsibility for coverage, or activities of a health care provider or health plan to obtain reimbursement for the provision of health care. Payment activities include billing, claims management, collection activities, eligibility determination and utilization review.

Health Care Operations: activities of a covered entity to the extent such activities are related to covered functions including quality assessment and improvement activities; credentialing health care professionals; insurance rating and other insurance activities related to the creation or renewal of a contract for insurance; conducting or arranging for medical review, legal services and auditing functions (including compliance programs); business planning such as conducting cost-management and planning analyses for managing and operating the entity including formulary development and administration, development or improvement of methods of payment or coverage policies; business management and general administrative activities; due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor is a covered entity or will become a covered entity; consistent with privacy requirements, creating de-identified health information, fundraising for the benefits of the covered entity, and marketing for which an individual authorization is not required.