Section: Medical Operations General
Subject: HIPAA COMPLIANCE AND PRIVATE HEALTH INFORMATION
Section #: 300.05
Issue Date: March 21, 2011
Revision Date: December 1, 2017
Approved By:  Michael Lozano, Jr., M.D., HCFR Medical Director

1. It shall be Department policy to ensure that Private Health Information (PHI) is not disclosed inappropriately.

2. Members of HCFR shall follow all Department standards in regards to the safeguarding of PHI.
    a. All information contained within this policy and the Department's full HIPPA compliance policy (located on the County computer system) shall be adhered to.

3. All HCFR members shall successfully complete training on HIPAA privacy and no member will be permitted to respond to a request for assistance until he/she has completed said training.
    a. No non-department member may ride on any HCFR apparatus until they have had documented training in HIPAA privacy and security rules.

4. All members will use discretion when obtaining patient information on scenes, en route to the hospital, and disseminating information at the hospital.
    a. This policy should not in any way interfere with the obtaining of necessary information for emergency treatment or patient care.

5. All members will ensure that PHI is not disclosed to persons not involved in the patient's treatment, billing for services, or other necessary department operations, unless specifically authorized by the Department's Privacy Liaison (Quality Management Chief).
    a. This includes disclosures to HCFR personnel not involved in the patient's care or quality assurance.

6. Any written documentation that includes PHI will be reasonably secured at all times.
    a. If PHI is to be transported, it will be done so in an approved container with a privacy statement attached.
    b. Any documented PHI will be secured at the station in the appropriate locked security box with the privacy statement affixed.
    c. No copies (e.g. no carbon required sheets) will be removed from written documents containing PHI, unless provided to person's involved in the patient's care.
    d. PHI will not be disposed of in the field without being shredded first.
        i. Example: a Tear and Go printout with any identifiable patient information or address, an internal report copy, etc.

7. Computer screens with PHI will be kept out of the view of any potential passersby and will not be left unattended.

8. Telephone or personal requests for any PHI (verbal or written) will be politely referred to the Department's Privacy Liaison.

9. PHI will not be:
    a. Documented by any student, observer, or other person that is identifiable to any patient.
        i. Example: a patient name, date of birth, etc.
    b. Transported unsecured in a vehicle.
    c. Sent via email or included in an email attachment.
    d. Left on voicemails, answering machines, etc.

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10. Work force members seeking reports or filed documents must coordinate through the Department's Privacy Liaison.

11. If sending a fax containing PHI to an approved recipient (e.g. Medical Examiner), ensure that you have a correct and current fax number and direct someone to be standing by to receive the fax.
    a. They should also be instructed to contact you immediately if there is a problem receiving.

12. All photocopying of PHI will be conducted in a reasonably secured area.

13. Station log books must be treated as PHI and must have a confidentiality notice affixed.

14. PHI shall ONLY be used for approved Department business as outlined by Department policy and applicable laws.
    a. At no time shall PHI be used for personal interest.