COMMUNITY MENTAL HEALTH CENTER
OF EAST CENTRAL GEORGIA
POLICY

SUBJECT:	**Minimum Necessary Standard**
POLICY NUMBER:	**PIM 3.06**
EFFECTIVE DATE:	**April 29, 2003**
RESCISSION DATE:	

SUPERSEDES:	**REVIEWED DATE:**
Policy # IM-27	**LAST REVISION DATE: November 7, 2003**

POLICY:

It is the policy of the Community Mental Health Center of East Central Georgia (CMHC) to comply with the Health Insurance Portability and Accessibility Act (HIPAA) requirement to use, disclose or request only the minimum amount of protected health information (PHI) necessary to accomplish the intended purpose or the use, disclosure or request.

DEFINITIONS:

I. Protected Health Information (PHI): Means individually identifiable information relating past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

II. Workforce Members: Employees, contractors, volunteers, students and other persons whose conduct, in the performance of work for the CMHC, is under the direct control of the CMHC regardless of whether they are paid by the entity.

PROCEDURES:

I. The CMHC and its workforce, will make reasonable efforts to ensure that the minimum necessary protected health information (PHI) is disclosed, used, or requested. Exceptions to the minimum necessary requirement include:
   A. Disclosures to the individual who is the subject of the information.
   B. Disclosures made pursuant to an authorization.
   C. Disclosures to or requests by healthcare providers for treatment purposes.
   D. Disclosures required for compliance with the standardized HIPAA transactions.
   E. Disclosures made to Health and Human Services (HHS) and Office of Civil Rights (OCR) pursuant to a privacy investigation; or
   F. Disclosures otherwise required by the HIPAA regulations or other law.

II. Each user of PHI will be subject to the provisions of Policy #PIM 3.03 (Access to Clinical Information) relating to staff access to PHI.

III. Reasonable efforts will be made to limit each PHI user's access to only the PHI that is needed to carry out his/her duties. These efforts will include the Privacy Officer monitoring staff use and disclosure of PHI.

IV. For situations where PHI use, disclosure or request for PHI occurs on a routine and recurring basis, the Privacy Officer will issue directives as to what information constitutes the minimum necessary amount of PHI needed to achieve the purpose of the use, disclosure or request.

V. For non-routine disclosures (other than pursuant to an authorization) staff should address questions to the Privacy Officer to assure the PHI is limited to that which is reasonably necessary to accomplish the purpose for which disclosure is sought. Examples of non-routine disclosures include providing PHI to accrediting bodies; insurance carriers, research entities, funeral homes, etc.

VI. Any questions related to this policy must be directed to the Privacy Officer.

VII. Failure to comply or assure compliance with this policy shall results in disciplinary action, up to and including dismissal.

VIII. The Privacy Officer will collect information during the month of April each year beginning in 2004 for the purpose of providing feedback to the Executive Director and the Leadership team to determine the compliance with the minimum necessary standard.

REFERENCES:

I. Public Law 104 – 191: 104th Congress

____________________________________ ___________________________
Acting Executive Director Date

____________________________________ ___________________________
CSB Chair Date

:PLN