MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

HIPAA DOCUMENTATION AND RECORD RETENTION

Effective Date: January 29, 2019 **Policy**: HI-18

I. PURPOSE: This policy addresses the documentation and record retention requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

II. POLICY: Montana State Hospital (MSH) will maintain documentation required for HIPAA compliance and will store such documentation for a period of a minimum of six years and three months. Documentation that is no longer required may be destroyed in a manner appropriate to Protected Health Information.

III. DEFINITIONS: None.

IV. RESPONSIBILITIES:

A. ***The Director of Health Information is the designated MSH Privacy Officer*** and will ensure appropriate documentation is maintained and destroyed as required by HIPAA.

V. PROCEDURE:

A. MSH will document all necessary policies for HIPAA compliance and will make all policies and procedures available to employees who deal with Protected Health Information in their work.

B. MSH will inventory and keep a record of all equipment, hardware and software. DPHHS Technology Services Division (TSD)/Network and Communications Bureau (NCB) will keep records of maintenance and security testing of such equipment.

C. The Health Information Department is responsible for receiving and processing authorizations to disclose Protected Health Information. All authorizations will be maintained on file for a period of six years and three months.

D. The Health Information Department is responsible for receiving and processing access to Protected Health Information. Denial of access to Protected Health Information will also be documented by these offices or persons.

E. The Health Information Department is responsible for processing requests to amend Protected Health Information. These offices will also document any circumstances where amendment was denied.

F. All MSH personnel who disclose Protected Health Information for purposes other than treatment, payment, health care operations, or in response to written authorizations will document such disclosures. The Privacy Officer will be responsible to collect and store such documentation logs for audit purposes. Client request for restrictions to uses and disclosures of Protected Health Information will be in writing and will be maintained by the Health Information Department.

G. MSH will maintain documentation of training regarding privacy and security issues and will document which personnel have received such training and with what frequency.

H. The Human Resources Department will maintain documentation of sanctions applied to employees for security violations.

I. The MSH Privacy Officer will document all circumstances where a client has requested and received an accounting of disclosures of Protected Health Information.

J. DPHHS the MSH Business Office will maintain a file of Business Associate Agreements and contracts.

K. MSH will maintain records of all Notices of Privacy Practices and subsequent changes to those notices.

L. DPHHS TSB/NCB Network Security Unit will keep documentation of the classifications of personnel and their level of access to Protected Health Information (See MOM. Information Technology, Security. POL-Information Security Policy - Appendix A (Baseline Security Controls), revised September 17, 2018.

M. The Privacy Officer will maintain a file of complaints received and corrective actions taken.

Destruction of Protected Health Information:

A. When documentation is no longer necessary or is otherwise scheduled for elimination, it will be destroyed in a manner to preserve protection of the Protected Health Information.

1. Paper documents will be shredded.
2. Electronic records will be deleted and all back up storage will be erased or destroyed.

VI. REFERENCES: The Health Insurance Portability and Accountability Act of 1996; DPHHS HIPAA Privacy Policy 008 titled HIPAA Documentation and Record Retention.

VII. COLLABORATED WITH: Hospital Administrator.

VIII. RESCISSIONS: HI-18, *HIPAA Documentation and Record Retention* dated February 22, 2014; HI-18, *HIPAA Documentation and Record Retention* dated November 2, 2009; HI-18, *HIPAA Documentation and Record Retention* dated October 30, 2006; HI-18, *HIPAA Documentation and Record Retention* dated August 1, 2003.

IX. DISTRIBUTION: All hospital policy manuals.

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Director of Health Information (Privacy Officer).

XII. ATTACHMENTS: None.

Signatures:

Kyle Fouts
Interim Hospital Administrator

Melinda Bridgewater
Director of Health Information