I. PURPOSE

The purpose of this policy is to explain how workforce members of the Stanford University HIPAA Components (SUHC) must make reasonable efforts to limit their use or disclosure of protected health information (PHI) or requests for PHI from an outside party to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

II. POLICY STATEMENT

In accordance with the HIPAA Privacy Rule, it is the policy of SUHC that when using or disclosing PHI, or when requesting PHI from an outside party, SUHC will make reasonable efforts to limit the amount of PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

III. PRINCIPLES

A. When using or disclosing protected health information (PHI), or when requesting PHI from an outside party, SUHC will make reasonable efforts to limit the amount of PHI to the minimum necessary.

B. SUHC shall develop and maintain the appropriate infrastructure to support the implementation of the minimum necessary requirement.

IV. PROCEDURES

A. When using or disclosing PHI, or when requesting PHI from an outside party, SUHC will make reasonable efforts to limit the amount of PHI to the minimum necessary.

1. The entire medical record may not be used, disclosed or requested unless it is specifically justified as the amount of PHI that is reasonably necessary to accomplish the intended use, disclosure or request.

2. Unless a valid, written authorization is obtained, it is SUHC policy to
apply the minimum necessary requirement to research activities:

a. In requesting access to SUHC PHI for purposes of research, the investigator must limit his/her request to the minimum amount of information necessary to complete the particular function or task, unless authorization is obtained.

b. In addition to the minimum necessary requirement, all uses and disclosures of PHI by members of the SUHC workforce for purposes of research are subject to the requirements set forth in the HIPAA: Research and Patient Privacy policy. (Refer to the Stanford University Administrative Panels on Human Subjects in Medical Research, Institutional Review Boards’ website at http://www.humansubjects.stanford.edu.)

3. It is SUHC policy to apply the minimum necessary requirement to business associates as set forth in SUHC policy H-05: Business Associates.

4. The minimum necessary requirement does not apply to certain uses and disclosures of, and requests for, PHI:

a. Requesting PHI from, or disclosing PHI to, another health care provider for purposes of treatment.

b. Disclosing PHI to the individual or to the individual’s personal representative as permitted by law (Refer to SUHC policy H-15: Use and Disclosure of PHI).

c. Using or disclosing PHI according to an individual’s or his/her personal representative’s authorization; (Refer to SUHC policy H-15: Use and Disclosure of PHI). PHI used, disclosed or requested pursuant to an individual’s authorization must be limited to the PHI expressly described in the authorization.
d. Disclosures that are required by law; (Refer to SUHC policy H-15: Use and Disclosure of PHI).

B. SUHC shall develop and maintain the appropriate infrastructure to support the implementation of the minimum necessary requirement.

1. During new employee orientation, or more often if the workforce member’s responsibilities change, the manager will review with the workforce member his/her access to PHI, including use and disclosure.

2. For each workforce member, managers must identify and document the following regarding routine access to, disclosure of, or requests for PHI:

   a. Members of the workforce who need the categories of PHI that the workforce members need to access;

   b. Any condition appropriate for the workforce members access to, disclosure of or request for PHI; and,

   c. For any necessary non-routine access to, disclosure of, or request for PHI, the specific amount of minimally necessary PHI must be determined on a case-by-case basis.

3. When making disclosures to public officials, workforce members may rely on the request as the minimum necessary, provided that the public official states that the information requested is the minimum necessary and verification procedures are followed in accordance with policy H-15: Use and Disclosure of PHI.

4. If the information is requested by another covered entity, the workforce member may rely on the request as the minimum necessary.

5. SUHC workforce members who have access to PHI will receive education and training about the minimum necessary requirement and
6. To meet the minimum necessary standard for the use of PHI, SUHC will:

   a. Identify those persons or groups of persons in each department or unit who need access to PHI to carry out their duties;
   b. Specify what categories of PHI each person or group may access and use, and under what conditions; and,
   c. Establish processes and/or controls to restrict unauthorized access to PHI.

7. To meet the minimum necessary requirement for disclosures to persons or entities outside of the Stanford Affiliated Covered Entity, SUHC will establish and implement:

   a. For routine and recurring types of disclosures, procedures to limit the PHI that may be disclosed to the amount reasonably necessary to achieve the purpose of the disclosure.
   b. For non-routine situations, additional procedures that include criteria designed to limit the PHI disclosed to the information reasonably necessary to accomplish the purpose for which disclosure is sought and review requests to determine if they meet these criteria.

8. Disclosure of requested PHI may be considered to be the minimum necessary for the stated purpose when the disclosure is permitted by law, reliance is reasonable in the circumstances, and the information is requested by:

   a. A public official or agency representing that the information is the minimum necessary for the stated purpose(s);
This policy applies to:
*Stanford University HIPAA Components (SUHC)*

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b. A health care provider;

c. A health plan;

d. A professional (e.g., attorney, accountant) who is a member of the Stanford Affiliated Covered Entity workforce for the purpose of providing professional services to SUHC, if the professional represents that the information requested is the minimum necessary for the stated purpose(s);

e. A business associate for the purpose of providing professional services to SUHC, if the business associate represents that the information requested is the minimum necessary for the stated purpose(s);

f. A researcher who has provided the required representations and documentation when accessing PHI for a research use that is:

1. Preparatory to research;
2. under a waiver of authorization;
3. for deceased individuals; or,
4. for a limited data set (refer to the SUHC HIPAA Research and Patient Privacy policy).

v. DOCUMENT INFORMATION

A. Legal Authority/References

- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Standards for Privacy of Individually Identifiable Health Information, 45
**This policy applies to:**
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**B. Review and Revision History**

*Note: SUHC Policies were restructured September 2013*

- (Version 2.0) November 2007
- (Version 3.0) September 2013, Privacy Office and Office of the General Counsel
- (Version 4.0) November 2014, Privacy Office
- (Version 5.0) January 2017 Office of the General Counsel; March 2017 Privacy Office

**C. Approvals**

- April 15, 2017, Stanford University Privacy Office

**D. Contact for Questions Related to this Policy**

Stanford University Privacy Office
privacy@stanford.edu
(650) 725-1828

Effective Date: April 30, 2017
Version 5.0