



University of Connecticut Health Center

POLICY NUMBER 2008-01

May 27, 2008

POLICY: DISPOSAL OF DOCUMENTS/MATERIALS CONTAINING PHI AND RECEIPT, TRACKING AND DISPOSAL OF EQUIPMENT AND ELECTONIC MEDIA CONTAINING ELECTRONIC PROTECTED HEALTH INFORMATION (Privacy & Security of Protected Health Information (PHI))

PURPOSE:

The purpose of the policy is to comply with the HIPAA Privacy & Security Rule's requirements pertaining to the destruction of documents and other materials containing PHI and the receipt, tracking and removal of hardware and electronic media that contain ePHI.

SCOPE:

Applies to all University of Connecticut Health Center (UCHC) workforce:

- Employees (including faculty and staff)
- Volunteers
- Students and residents
- Temporary staff
- Agency and contracted staff
- Credentialed staff
- Members of the Board of Directors

POLICY/PROCEDURE STATEMENT:

UCHC has a duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements. This policy defines the guidelines and procedures that must be followed when disposing of information containing PHI and ePHI. All supervisors are responsible for enforcing this policy. Individuals who violate this policy will be subject to the disciplinary process as outlined in the HIPAA sanctions policy.

1. Destruction of Paper Copies and Original Documents (Day-to-Day Disposal)
 - Any printed material (e.g., faxes, printed emails, informal notes about patients, patient identification stickers) containing PHI must not be discarded in trash bins, unsecured recycle bins or other publicly accessible locations. Instead this information must be personally shredded or placed in secured shredder bins. UCHC Department Heads shall provide users with access to shredders or

secured shredder bins for proper disposal of confidential printouts containing PHI.

- The user may elect to use either shredding or secured shredder bins, as long as the destruction is in accordance with this policy. It is the individual's responsibility to ensure that the document has been secured or destroyed. It is the supervisor's responsibility to ensure that their employees are adhering to the policy.
- After documents have reached their retention period according to the State of Connecticut Record Retention Schedule, all PHI must be securely destroyed.

2. Disposal of patient identification cards and wrist bands

These items should be discarded in shredding bins ONLY

3. Destruction of X-ray film

The State of Connecticut Record Retention Schedule is used to determine the schedule for X-ray film destruction. X-rays to be destroyed are handled by the Materials Management Department and an outside firm does final destruction using secure methods.

4. PHI Disposal in Regulated Medical Waste

Red Bag Waste must be placed in regulated medical waste bins. All regulated medical waste trash is incinerated using secure methods.

5. Documentation of PHI Disposal

To ensure that it is in fact performed, UCHC personnel or a bonded destruction service must carry out the destruction of PHI.

- If UCHC personnel undertake the destruction of the records, the UCHC personnel must use the UCHC records destruction form RC108, provided by the State Library, Department of Records Management. The record schedule must be found in the Records Retention Manual for the department requesting destruction of the records. If the record retention schedule is not found, please contact the UCHC Records Management Officer. Records cannot be destroyed without the approval of the State Records Administrator. Please see the attached Web site for more complete information regarding records retention at [University of Connecticut Health Center \(http://opa.uhc.edu/record.htm\)](http://opa.uhc.edu/record.htm).

- If a bonded shredding company is utilized for the final destruction of the records, the company must provide UCHC with a manifest of destruction that contains the following information: 1) Date of destruction, 2) Method of destruction, 3) Description of the disposed records, 4) Inclusive dates covered, 5) A statement that the records have been destroyed in the normal course of business, 6) The signatures of the individuals supervising and witnessing the destruction. Materials Management's, Records Management division will maintain destruction documents permanently. Upon request the Records Management department and the bonded shredding company must provide the Chief Privacy Officer with the certificate of destruction.

6. Hardware (Biomedical & non-biomedical)

Departments shall follow procedures in the Materials Management UCHC Inventory Control Manual (http://opa.uchc.edu/opa_inv/pam_home.html) related to receipt, removal, storage, re-use and disposal of hardware.

Hardware shall be controlled and accounted for at all times through the Property Administration Department or (if biomedical equipment) Clinical Engineering Department.

All hardware shall be assigned an owner.

There shall be a record of the movements of all hardware containing ePHI, the owner and the designated individual(s) responsible for the movement.

The movement of hardware shall be authorized and logged by the department manager prior to the hardware and electronic media entering or leaving a facility.

The department manager shall be accountable for hardware while in transit between facilities.

Hardware shall be properly logged and disposed of when no longer used.

ePHI shall be removed from hardware before it is made available for reuse.

A retrievable, exact copy of ePHI, (when needed or requested) shall be created before any movement of hardware.

7, Electronic Media (Biomedical and non-biomedical)

Electronic media containing PHI shall be physically destroyed when no longer used or no longer needed.

References: State of Connecticut HIPAA Security Policy
45 C.F.R. §164.310(d) (1)
45 C.F.R. §164.310(d) (2)
Property Administration Manual
Hospital Administration Manual

Iris Mauriello (signed)

June 10, 2008

Corporate Compliance Integrity/Privacy Officer

Date

Jonathan Carroll (signed)

June 16, 2008

Information Security Officer

Date

Peter Deckers, M.D. (signed)

June 18, 2008

Executive Vice President for Health Affairs

Date

Replaces Policies: #2003-10 issued 6/15/05 and updated 11/01/05 and #2005-09 issued 1/28/05