# Uses and Disclosures of PHI

A covered entity may not use or disclose protected health information (PHI) unless:

- The Privacy Rule **requires** the use or disclosure;
- The Privacy Rule **permits** the use or disclosure; or
- The individual who is the subject of the information (or the individual's personal representative) **authorizes** the use or disclosure in writing.

In addition, a covered entity must make reasonable efforts and implement policies and procedures to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. This is called the "**minimum necessary standard**."

## Required Disclosures

A covered entity **must** disclose protected health information in **only two situations**:

1. To individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and
2. To HHS when it is undertaking a compliance investigation or review, or an enforcement action.

## Permitted Uses and Disclosures

A covered entity is generally permitted to use and disclose protected health information **without an individual's authorization** for the following purposes or situations:

- To the individual who is the subject of the information;
- Treatment, payment, and health care operations (see expanded definition below);
- Uses and disclosures where the person who is the subject of the information has had an opportunity to agree or object (see expanded definition below);
- Incident to an otherwise permitted use and disclosure; and
- Public interest and benefit activities (**including disclosures for workers' compensation purposes**).

### Treatment, Payment, and Health Care Operations

A covered entity may use and disclose protected health information for its own treatment, payment, and health care operations activities. These activities include, among other things:

- The provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation and referral between providers;
- Activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual;
- Case management and care coordination;
- Provider performance evaluation, credentialing, and accreditation; and
- Business planning, development, management, and administration.

### Uses and Disclosures with the Opportunity to Agree or Object

Informal permission may be obtained by asking the individual outright, or by **circumstances that clearly give the individual the opportunity to agree, acquiesce, or object**. Where the individual is incapacitated, in an emergency situation, or not available, covered entities generally may make such uses and disclosures, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.

For example, informal permission may be relied upon for the following common purposes:

- To list the individual's name, general condition, religious affiliation, and location in the provider's facility directory;
- To disclose to the individual's family, relatives, or friends, or to other persons whom the individual identifies, protected health information directly relevant to that person's involvement in the individual's care or payment for care; and
- Notifying (including identifying or locating) family members, personal representatives, or others responsible for the individual's care of the individual's location, general condition, or death.

Additional rules apply to permitted uses and disclosures. For more information, click here.

## Authorized Uses and Disclosures

A covered entity must obtain the individual's **written authorization** for any use or disclosure of protected health information that is not required or permitted by the Privacy Rule.

A written authorization **must** contain these "core elements":

1. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
2. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
3. The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.
4. A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
5. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.
6. Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.

In addition to the core elements, the Privacy Rule **also requires** that the written authorization contain statements adequate to place the individual on notice of all of the following:

1. The individual's right to revoke the authorization in writing, **and either**:
    - The exceptions to the right to revoke and a description of how the individual may revoke the authorization; **or**
    - A reference to the covered entity's notice.
2. The ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the authorization, by stating **either**:

    - The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; **or**
    - The consequences to the individual of a refusal to sign the authorization when the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.
3. The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer be protected.

**Note**: A covered entity generally **may not** condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization.

**Click here for more information on authorized uses and disclosures.**

## Minimum Necessary Standard

A covered entity must make reasonable efforts and implement policies and procedures to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. This is called the "**minimum necessary standard**."

When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

The minimum necessary standard is **not imposed** in any of the following circumstances:

- Disclosure to or a request by a health care provider for treatment;
- Disclosure to an individual who is the subject of the information, or the individual's personal representative;
- Use or disclosure made pursuant to an authorization;
- Disclosure to HHS for complaint investigation, compliance review, or enforcement; or
- Disclosures required by regulation or law.

**For additional guidance on the minimum necessary standard, click here.**