Banner Health

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Approved by: PolicyTech Administrators , Meloney Broadway		
Discrete Operating Unit/Facility: **Banner Health Insurance Division**		BUHP\BMA Compliance

I. Purpose and Population:

A. This policy applies to all Banner Medicaid and Medicare lines of business.

B. To ensure Banner Medicaid and Medicare Plans implement appropriate processes to protect member's Protected Health Information (PHI). Banner Medicaid and Medicare Plans educate members, employees, and First Tier, Downstream and Related Entities (FDRs) about the ways in which member's may obtain or otherwise manage access to their PHI in accordance with Banner Medicaid and Medicare Plans' and Banner Health's code of conduct and as required by the Health Insurance Portability and Accountability Act (HIPAA).

II. Definitions:

A. Please refer to the link below for full definitions:
Policy Definitions

III. Policy:

A. Banner Medicaid and Medicare Plans take appropriate measures to secure and protect member PHI and communicate these measures to members. Banner Medicaid and Medicare Plans provide members with mechanisms to access and manage their PHI. Banner Medicaid and Medicare Plans will use and disclose PHI in accordance with the uses and disclosures stated within the applicable Privacy Notice.

IV. Procedure/Interventions:

A. Banner Medicaid and Medicare Plans have established protocols to maintain secured access to Banner Medicaid and Medicare Plans computer systems, electronic mail, internet and to remove access for terminated employees upon employee exit.

B. Mandatory HIPAA Education

1. As a condition of employment with Banner Medicaid and Medicare Plans, all Banner Medicaid and Medicare Plans' employees are required to receive mandatory education on HIPAA within 60 days of hire or association with Banner Medicaid and Medicare Plans and annually thereafter. (Note: During National/State emergencies, due dates are extended to 120 days for new employees).
    a. All Banner Medicaid and Medicare Plans' FDRs are required to sign a Business Associates Agreement (BAA) and to abide by the BAA's HIPAA requirements.
    b. Banner Medicaid and Medicare Plans Compliance Department ensures annual training and education for Banner Medicaid and Medicare Plans' employees. Participation in these educational programs will be documented in the MyHR Workday Learning.

C. Banner Medicaid and Medicare Plans Employee "Need to Know"
    1. In accordance with Banner Plans and Networks Policy CP 5006 Health Plan Privacy and Security Safeguards, only Banner Medicaid and Medicare Plans employees with legitimate "need to know" may access, use, or disclose PHI. Employees may only access, use or disclose the minimum information necessary to perform his or her designated role regardless of the extent of access provided.
    2. Banner Medicaid and Medicare Plans identify those employees who need access to PHI in order to carry out their duties as well as the type of PHI access needed.
        a. Each Department is responsible for identifying any conditions that may have an impact on an employee's ability to access and/or disclose the PHI they are authorized to access.

D. Minimum Necessary
    1. Banner Medicaid and Medicare Plans will make reasonable efforts to limit access of PHI to what is necessary to carry out Banner Medicaid and Medicare Plans duties, functions and/or responsibilities.
    2. Internal and external requests to access PHI must be in compliance with this policy and may be reviewed by the Compliance Department to determine whether it meets the minimum necessary requirements.
    3. Banner Medicaid and Medicare Plans' employees will only use and disclose the amount of PHI minimally necessary except in the following circumstances:
        a. When the PHI is for use by or a disclosure to a healthcare provider for purposes of providing treatment to the patient;
        b. When the disclosure is to the member or the member's legally authorized representative;
        c. When the disclosure is pursuant to a valid authorization, in which case, the disclosure will be limited to the PHI specified on the authorization;
        d. When the disclosure is to the Secretary of Health and Human Services; or
        e. When the disclosure is required by law**.**

E. Banner Medicaid and Medicare Plans Use and Disclosures of PHI
    1. Banner Medicaid and Medicare Plans will not disclose PHI unless permitted by Banner Health Corporate or Banner Medicaid and Medicare Plans policies or as required by law. Member Protected Health Information (PHI) may be shared with a Covered Entity for purposes of treatment, payment, or health care operations or with the member or member's authorized representative when requested and properly authorized.
    2. Health Care Operations include a wide range of day-to-day activities that support the conduct of business for Banner Medicaid and Medicare Health Plans. These include the following activities:

a. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines.
b. Population-based activities relating to improving health or reducing health care costs, protocol development, case/care management and care coordination, contacting health care providers and members with information about treatment alternatives, and related functions that do not include treatment of members.
c. Reviewing the competence or qualifications of health care professionals or evaluating practitioner and provider performance.
d. Evaluating health plan performance.
e. Conducting training programs in which for practitioners to practice or improve their skills as health care providers, or training of non-health care professionals.
f. Accreditation, certification, licensing, or credentialing activities.
g. Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of health insurance contracts or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance).
h. Conducting or arranging for medical review, legal services, and auditing functions, including fraud, waste, and abuse detection and compliance programs.
i. Business planning and development such as conducting cost-management and planning -related analyses related to managing and operating Banner Medicaid and Medicare Health Plans, including formulary development and administration, development, or improvement of methods of provider/vendor payment or coverage policies.
j. Business management and general administrative activities of Banner Medicaid and Medicare Health Plans, including, but not limited to:
    i. Management activities relating to implementation of and compliance with the HIPAA Privacy and Security Standards.
    ii. Customer service, including the provision of data analyses and sharing of data with applicable providers.
    iii. Resolution to internal grievances.
    iv. Creating de-identified health information or a limited data set.

3. Banner Medicaid and Medicare Plans does not use or disclose PHI for the purpose of underwriting and denial of services, coverage, and benefits.
4. Banner Medicaid and Medicare Plans does not use or disclose PHI for the purpose of research.
5. Banner Medicaid and Medicare Health Plans may use or disclose PHI for the following purposes:
    a. To access health care disparities.
    b. To design intervention programs.
    c. To design and direct outreach materials.
    d. To inform health care practitioners and providers about individuals language needs and pronouns.
    e. To provide clinical care.

F. Notice of Privacy Practice (NOPP)
1. Banner Medicaid and Medicare Plans has developed and maintains HIPAA-compliant NOPPs.
2. The NOPPs are used to notify Banner Medicaid and Medicare Plans' members of their rights and responsibilities with respect to their PHI. The NOPPs also advise members of Banner Medicaid and Medicare Plans' responsibilities with respect to the PHI Banner Medicaid and Medicare Plans create, collect, and maintain.

3. The NOPPs contains all HIPAA-required elements and describe how Banner Medicaid and Medicare Plans may use and disclose a member's PHI. The NOPPs state Banner Medicaid and Medicare Plans' duties to protect member privacy, provide a notice of privacy practices and abide by the terms of the current NOPP. The NOPPs describe a member's rights.
4. The NOPPs include a point of contact for further information and for making complaints to Banner Medicaid and Medicare Plans.
5. The NOPPs will be in plain language and consistent with applicable laws, rules, and regulations.,
6. The NOPPs will be in English and Spanish and any other language when 1,000 or 5%, whichever is less, members that speak that language have a Limited English Proficiency (LEP).
7. The NOPPs will be made available to members in paper and on Banner Medicaid and Medicare Plans' websites. The NOPPs will be posted in a clear and prominent place in Banner Medicaid and Medicare Plans offices.
8. The NOPPs are made available to prospective members through Banner Medicaid and Medicare Plans websites and are included with sales and marketing materials.
9. The NOPPs will be issued to each new member upon member's enrollment and members will be reminded annually that a current NOPP can be viewed on Banner Medicaid and Medicare Plans websites and are available upon request.
10. The member's right to privacy and right to request a NOPP will be included in member materials which are disseminated to members at time of enrollment and all enrollment renewals or re-enrollment.
11. The Customer Care and Marketing Departments are responsible for maintaining the NOPPs on the websites and on materials. The Senior Director, Compliance, is responsible for updating the NOPPs. Material revisions to the NOPPs will require redistribution of the NOPPs to all Banner Medicaid and Medicare Plans' members within 60 days of revision.

G. Member Rights
   1. Rights are granted to members related to their Banner Medicaid and Medicare Plans Record:
      a. The right to inspect their health information and to obtain a copy of their Banner Medicaid and Medicare Plans' Record. Members are given a choice of receiving a paper copy or an electronic email (encrypted or not) copy of their record. Members are provided with information that there is some level of risk that a third party could access their PHI without the member's consent when email is unencrypted, and Banner Medicaid and Medicare Plans are not responsible for unauthorized access or for any risks such as a virus to the member's computer/device when receiving the PHI in an email. Under very limited situations, a member's request may be denied, such as a request for psychotherapy notes.
      b. The right to request an Amendment to their Banner Medicaid and Medicare Health Plans Record.
      c. The right to an accounting of disclosures of the member's Banner Medicaid and Medicare Health Plans Record made by Banner Medicaid and Medicare Plans.
      d. The right to request restrictions on the uses and disclosures of the member's Banner Medicaid and Medicare Plans Record made by Banner Medicaid and Medicare Plans. The right to request that Banner Medicaid and Medicare Plans communicate confidentially with them about their health information in a certain way or at certain locations.
      e. The right to receive a paper copy of the NOPP even if the member has requested or obtained it electronically.

f. The right to complain to Banner Medicaid and Medicare Plans, the Department of Health and Human Services or the Office of Civil Rights if the member believes their privacy rights have been violated.
g. The right to be notified if the member is subject to a breach of unsecured protected health information.
h. Some rights require action on the part of the member before Banner Medicaid and Medicare Plans can respond. This includes the member contacting Banner Medicaid and Medicare Plans' Customer Care Center and making any requests in writing and providing a reason that supports their request.

H. Member's Right to Inspect or Obtain Copies of Member's Banner Medicaid and Medicare Plans' Records
1. Banner Medicaid and Medicare Plans have implemented a process to fulfill member requests to access or release some or all of their health information.
2. Requests to release Banner Medicaid and Medicare Plans Records must be accompanied by a member signed authorization. Banner Medicaid and Medicare Plans has created an "Authorization for Use, Inspection and Disclosure of Protected Health Information" form (Release Authorization). Either the Release Authorization or member-created alternative may be used. Any member-created forms to release records that are not Banner Medicaid and Medicare Plans Authorization Release may be accepted as long as these alternative forms contain the ten requirements listed in Banner Medicaid and Medicare Plan's Request for Medical Records Desktop.
3. The Release Authorization must include the following:
a. Information to be disclosed;
b. Name, address etc. of individual/organization to whom Banner Medicaid and Medicare Plans Records should be released;
c. The purpose for disclosing the information;
d. A statement informing the member of his or her right to revoke the authorization in writing, how to revoke the authorization and any exceptions to the right to revoke;
e. A statement that information disclosed pursuant to the authorization may be redisclosed by the recipient and is no longer protected by federal privacy regulations unless bound by other regulations such as Part 2 or Arizona Confidential Communications regarding communicable diseases - ARS 36-664;
f. A statement that the authorization will expire either on a specific date, after a specific amount of time or upon the occurrence of some event related to the member;
g. Agree/Disagree to release Banner Medicaid and Medicare Plans Records on Drug/Alcohol Abuse, Psychiatric and HIV/AIDS Genetic Testing records;
h. If a member-created form to release records does not contain the ten requirements, The Banner Medicaid and Medicare Plans' Compliance Department will send the Banner Medicaid and Medicare Plans' Authorization Form to the requestor for completion before proceeding.
i. Upon receipt of an appropriately completed and signed Release Authorization, and a copy of identification (Driver's License or Picture ID) or confirmation of the member or authorized representative's identity from the Banner Medicaid and Medicare Plan's ALTCS Case Manager, the Compliance Department will review the request and determine if Banner Medicaid and Medicare Plans Records can be released. In the event the copy of identification is not received with the release form, the custodian of records or designee will contact the member with the information contained in Banner Medicaid and Medicare Plans Record to confirm the release was sent by the member, if applicable. The records will be provided in the form and format requested by the member if it is readily producible in such form or format; or if

not, in a readable hard copy form or such other form or format as agreed upon by Banner Medicaid and Medicare Plans Compliance Department and the member.

4. If the Banner Medicaid and Medicare Plans' Compliance Department determines the request can be fulfilled, the Compliance Department will collect the requested information and supply a copy to the member at no cost. The member will not be charged if the member has only requested to inspect the member's Banner Medicaid and Medicare Plans Record.
5. Under limited situations where the request may be denied, such as a request for psychotherapy notes, the Senior Director, Compliance, in consultation with the Chief Medical Officer will review and approve all denials and the member will be notified of the reasons for the denial in writing. Banner Medicaid and Medicare Plans' Compliance Department will make clear the member's rights to a review of the denial of access.
6. Banner Medicaid and Medicare Plans' Compliance Department will fulfill member requests no later than 30 days of receipt of appropriate written request and the completed Authorization Form. If Banner Medicaid and Medicare Plans' Compliance Department is unable to take action within 30 days, Banner Medicaid and Medicare Plans may take an additional 30 days provided Banner Medicaid and Medicare Plans' Compliance Department advises the member of the reason for the delay and provides the date the request will be completed. The Compliance Department is responsible for this communication to the member or authorized representative.
7. In the event an Authorization form is not returned to Banner Medicaid and Medicare Plans, the Service Request in the Customer Relationship Management System (CRM) for Banner Medicaid and Medicare Plans Records will be closed after 30 days.

I. Member's Right to Amend Member's Banner Medicaid and Medicare Plans Record
   1. Banner Medicaid and Medicare Plans have implemented a process to fulfill a member's requests to Amend the member's Banner Medicaid and Medicare Plans Records due to Banner Medicaid and Medicare Plans Record being incorrect or incomplete.
   2. Upon receipt of a written request to Amend the member's Banner Medicaid and Medicare Plans Record from a member or a member's authorized representative, the Compliance Department will review the request and consult with licensed clinical professionals or other subject-matter experts from the appropriate Banner Medicaid and Medicare Plans Department to determine if the health information in Banner Medicaid and Medicare Plans Record is incorrect or incomplete.
   3. After the Compliance Department and subject-matter experts evaluate the accuracy and completeness of Banner Medicaid and Medicare Plans Record, they will advise the Senior Director, Compliance, of their findings. The Senior Director, Compliance, will then review the findings and any associated documents to determine whether to grant or deny the Amendment request.
   4. If the Senior Director, Compliance, determines the Amendment request can be fulfilled, the Compliance Department will ensure the member's Banner Medicaid and Medicare Plans Record is corrected and will provide the member or authorized representative with written confirmation of the Amendment. When the correction is made, Banner Medicaid and Medicare Plans' Compliance Department in conjunction with the applicable department will make reasonable efforts to see that the corrected information is provided to Banner Medicaid and Medicare Plans FDRs, if applicable.
   5. If the Senior Director, Compliance, determines the Amendment request is denied, the Senior Director, Compliance will document the reason(s) for denial and notify the member or member's authorized representative of the denial. Notification of denial must include:
      a. The basis /reason for denial;

b. A notification of the member's right to submit a written "statement of disagreement" with the denial. If the member submits a written "statement of disagreement," Banner Medicaid and Medicare Plans will include the member's "statement of disagreement" in the member's Banner Medicaid and Medicare Plans Record. Banner Medicaid and Medicare Plans must provide documentation of the dispute with any subsequent disclosure of the disputed PHI.
c. A description on how the member or member's authorized representative can file a complaint with Banner Medicaid and Medicare Plans, the Department of Health and Human Services or the Office of Civil Rights pursuant to HIPAA.

6. The Custodian of Records will ensure all Correction Amendments are maintained and stored in accordance with Federal and State laws in accordance with Banner Plans and Networks Policy CP 5230 Custodian of Records.
   a. Banner Medicaid and Medicare Plans will act on the Amendment request within 60 days. If, under certain circumstances, Banner Medicaid and Medicare Plans cannot fulfill the request in 60 days, Banner Medicaid and Medicare Plans Compliance Department will notify the member in writing of reasons and their intent to extend an additional 30 days.

J. Member's Right to Request to Receive an Accounting of Disclosures of Member's PHI
   1. Banner Medicaid and Medicare Plans' have implemented a process to fulfill a member's request to receive an accounting of Banner Medicaid and Medicare Plans' disclosures of the member's PHI.
   2. The NOPPs supply the member with instructions on how to request an accounting of disclosures. The member must contact Banner Medicaid and Medicare Plans' Customer Care Center to obtain and complete an "Accounting for Disclosure Authorization Form" (AD Form).
   3. Once the member sends the completed AD Form to Banner Medicaid and Medicare Plans, the Compliance Department will research the request, collect the requested disclosure information, and send the information (up to six years) to the member.
   4. The first request is free. Any additional request within a 12-month period may incur a fee.
   5. Banner Medicaid and Medicare Plans' Compliance Department will provide the member with an accounting of disclosures within 60 days of request.

K. Member's Right to Request a Restriction on Use or Disclosure of Member's Health Information
   1. Banner Medicaid and Medicare Plans have implemented a process to fulfill a member's request for restrictions on use or disclosure of member's Banner Medicaid and Medicare Plans Record, in electronic or any other form.
   2. The NOPPs supply the member with instructions on how to request a restriction. The member must submit the request for restriction in writing.
   3. Once the request is received by Banner Medicaid and Medicare Plans, Banner Medicaid and Medicare Plan's applicable department must agree to the restrictions unless the disclosure is for the purposes of carrying out payment or health care operations and is not otherwise required by law. The PHI restriction will be posted as a flag or an alert on the member's account in all Banner Medicaid and Medicare Plans' Systems.
   4. If Banner Medicaid and Medicare Plans disagree to the restrictions, the Senior Director, Compliance, will document the reasons for disagreement, which are limited to carrying out payment or health care operations or as otherwise required by law. A written notice of disagreement will be sent to the member by the Compliance Department.
   5. Banner Medicaid and Medicare Plans may not use or disclose the member's restricted information, except that, if the member who requested the restriction is in need of

emergency treatment and the restricted PHI is needed to provide the emergency treatment.

6. In the event any Banner Medicaid and Medicare Plans' Staff provides the restricted PHI to a provider for emergency treatment, the disclosure will include the request to the providers not to further use or disclose restricted information which was disclosed for emergency purposes.
7. The termination of a restriction may occur as follows:
   a. The member agrees to or requests a termination in writing;
   b. The member orally agrees to the termination and the oral agreement is documented;
   c. Banner Medicaid and Medicare Plans Compliance Department Staff informs the member that it is terminating its agreement to a restriction, except that such termination is not effective for PHI restricted through HIPAA laws and regulations and is only effective with respect to PHI created or received after Banner Medicaid and Medicare Plans has informed the member.
8. Banner Medicaid and Medicare Plans will fulfill the request within 30 days of receipt of written request.

L. Member's Right to Request for Confidential Communication by Alternative Means or Alternative Locations
   1. Banner Medicaid and Medicare Plans have implemented a process for member's requests for confidential communications by alternative means or at alternative locations.
   2. The NOPPs supply the member with instructions on how to request confidential communications by alternative means or at alternative locations. The member must submit the request in writing.
   3. Once the request is received by Banner Medicaid and Medicare Plans, if the member clearly states that the disclosure of all or part of the member's PHI could endanger the member, Banner Medicaid and Medicare Plans must accommodate the request to receive communications of PHI from Banner Medicaid and Medicare Plans by alternative means or alternative locations. The member's contact information will be updated in all Banner Medicaid and Medicare Plans' Systems, and an alert will be posted in Banner Medicaid and Medicare Plans Customer Relationship Management System (CRM) on the member's account.
   4. If the member is an AHCCCS member, Customer Care Staff are required to change member contact information within the AHCCCS system. Telephone number and mailing address changes are made by Customer Care Staff logging into the AHCCCS System to make the change if the address remains within the same county. Address changes outside of the county must be made by the member contacting AHCCCS directly.
   5. Banner Medicaid and Medicare Plans' Compliance Department will supply the member with written confirmation of Banner Medicaid and Medicare Plan's agreement to the member's request.
   6. If Banner Medicaid and Medicare Plans deny the member's request for any reason, Banner Medicaid and Medicare Plan's Senior Director, Compliance, will notify the member in writing of the reason for the denial.
   7. Banner Medicaid and Medicare Plans will fulfill the request within 30 days of receipt of written request or immediately (within one business day) if the member clearly states that the disclosure of all or part of the member's PHI could endanger the member.

M. Discipline for Non-Compliance
   1. Banner Medicaid and Medicare Plans will take disciplinary action against any employee or FDR who fail to comply with the Banner Health Corporate or Banner Medicaid and

Medicare Plans Codes of Conduct, or policies, Federal and State laws, and requirements.

a. Employees and FDRs are made aware that failure to report violations due to negligence or reckless conduct may result in disciplinary action.
b. Disciplinary actions for FDRs range from contract sanctions to immediate contract termination, as appropriate.

V. Procedural Documentation:

A. Banner Medicaid and Medicare Plans are fully compliant to all HIPAA requirements related to member rights and responsibilities.
B. The NOPPs comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and are reviewed annually by the Compliance Officers and the Banner Privacy Department.

VI. References:

A. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
B. The Health Information Technology for Economic and Clinical Health Act (HITECH)
C. HIPAA Omnibus Rule
D. Medicare regulations governing Parts C and D found at 42 CFR§ § 422 and 423, respectively.
E. NCQA Members Rights and Responsibilities
F. Banner Health Insurance Division Compliance Program and Fraud, Waste and Abuse Plan.
G. Title 45 of the CFR, Part 164.522
H. Title 45 of the CFR, Part 164.526
I. Title 45 of the CFR, Part 164.528
J. Title 45 of the CFR, Part 164.508
K. Title 42 of the CFR, Part 2 – Confidentiality of Substance Use Discorded Patient Records
L. ARS 36-664
M. Medicare Managed Care Manual – Chapter 21 – Section 50.3.1 General Compliance Training
N. Prescription Drug Manual – Chapter 9 – Section 50.3.1 General Compliance Training
O. AHCCCS Complete Care Contract, Section D, Paragraph 20, Medical Records
P. AHCCCS EPD ALTCS Contract, Section D, Paragraph 78, Medical Records

VII. Related Policies/Procedures:

A. Banner Plans and Networks Policy: CP 5230 Custodian of Records
B. Banner Plans and Networks Policy: CP 5022 Maintenance and Retention of Health Plan Documents
C. Banner Plans and Networks Policy: CP 5006 Health Plan Privacy and Security Safeguards
D. Banner Health Policy: 1323 Notice of Privacy Practices
E. Banner Health Policy: 381 Contracting with Business Associates
F. Banner Health Policy: 382 Authority to Request Protected Health Information (PHI)
G. Banner Health Policy: 388 Disclosures of Protected Health Information (PHI) to Correctional Institution or Other Law Enforcement Officials with Custody Over a Patient
H. Banner Health Policy 390 Disclosures of Protected Health Information (PHI) to Law Enforcement/Government Officials
I. Banner Health Policy: 1336 Use and Disclosure of Protected Health Information (PHI) Requiring Patient Authorization
J. Banner Health Policy: 405 Use and Disclosure of Mental Health Information
K. Banner Health Policy: 404 Use and Disclosure of Alcohol and Drug Abuse Records

L. Banner Health Policy: 408 Using, Disclosing and Requesting the Minimum Necessary Amount of Protected Health Information (PHI)
M. Banner Health Policy: 406 Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations (TPO)
N. Banner Health Policy: 396 Patient Request for Records
O. Banner Health Policy: 409 Patient Request to Amend or Supplement Records
P. Banner Health Policy: 395 Patient Request for Accounting of Disclosures of Protected Health Information (PHI)
Q. Banner Health Policy: 389 Disclosures of Protected Health Information (PHI) Required by Law
R. Banner Health Policy: 1466 Disclosures of Protected Health Information (PHI) in Judicial and Administrative Proceedings - Arizona
S. Banner Health Policy: 1335 Use and Disclosure of Protected Health Information (PHI) Concerning Decedents
T. Banner Health Policy: 401 HIPAA Privacy and Security Mandatory Training
U. Banner Health Policy: 2284 HIPAA Sanctions Policy
V. Banner Health Policy: 1333 Disclosures of Protected Health Information (PHI) to Family Members and Persons Involved in an Individual's Care
W. Banner Health Policy: 399 Protected Health Information Breach Notification
X. Banner Health Policy: 410 Workforce Confidentiality

VIII. Keywords and Keyword Phrases:

A. Notice of Privacy Practice
B. Protected Health Information
C. HIPAA