NEW YORK UNIVERSITY
HIPAA Information Security Policies, Specifications, and Definitions

Title: Policy 15. Access Control
Effective Date: January 1, 2005
Reviewed: August 13, 2021
Revised: April 10, 2020
Issuing Authority: Executive Vice President; Vice President for Information Technology and Global University Chief Information Officer
Responsible Officer: Executive Vice President; Vice President for Information Technology and Global University Chief Information Officer

Policy
New York University and each covered component strives to protect the confidentiality, integrity, and availability of EPHI by taking reasonable and appropriate steps to ensure that EPHI Systems support and are installed with technical safeguards to control and restrict access to such EPHI Systems to persons and software programs that are authorized to have such access in accordance with New York University’s Information Access Management policy (HIPAA Policy 5). Who is affected by this policy is documented in HIPAA Policy 1 – Overview: Policies, Procedures, and Documentation.

Purpose of this Policy
Although access controls, as required by the HIPAA Security Regulations, may differ under normal and emergency conditions, they are integral to the safeguarding of electronic protected health information. This policy reflects New York University’s commitment to comply with such Regulations.

Scope of this Policy
Affected by these policies are all covered components that may be designated by the University from time to time, including the NYU School of Medicine, NYU College of Dentistry, and the Student Health Center, and areas designated part of the health care component of the University from time to time but only to the extent that each component performs activities that would make such component a business associate of a component of the University that performs covered functions if the two components were separate legal entities (i.e., support components), including the Office of the Bursar, Controller’s Division, including Accounts Payable, NYU Information Technology (NYU IT), Office of Insurance and Risk Management, Internal Audit, Office of Compliance and Risk Management, Office of General Counsel, Office of Sponsored Programs, University Relations and Public Affairs, Public Safety, Treasury Applications, and University Development and Alumni Relations. The NYU School of Medicine follows HIPAA-related policies and procedures created specifically for its environment; School of Medicine compliance with HIPAA is coordinated through Langone Medical Center. These policies affect all NYU workforce members in covered components.

Operational Requirements
A. Each covered component shall take reasonable and appropriate steps to support appropriate types of access control technology for EPHI Systems.
B. New York University will implement appropriate technical security controls and methods that permit access to EPHI Systems only to authorized persons as set forth in the operational specifications below in this policy, including:
   1. Unique user identifiers (user IDs) that enable workforce members to be individually identified and tracked (no redundant user IDs) as set forth in the Unique User Identification operational specification (see 15.A).
2. **Emergency access** procedures that enable **authorized workforce members** to obtain **access** to necessary **EPHI** during a **disaster** or other **emergency** as set forth in the **Emergency Access Procedure operational specification** (see 15.B).

3. Automatic log-off from **EPHI Systems** of **workforce members** from their **workstations** as set forth in the **Automatic Logoff operational specification** (see 15.C).

4. Encryption of **EPHI** on **EPHI Systems** as reasonable and appropriate as set forth in the **Encryption and Decryption operational specification** (see 15.D)

C. **HIPAA REGULATORY INFORMATION**

**CATEGORY:** Technical Safeguards  
**TYPE:** Standard  
**HIPAA HEADING:** Access Control  
**REFERENCE:** 45 CFR 164.312(a)(1)  
**SECURITY REGULATION STANDARDS LANGUAGE:** “Implement technical policies and procedures for electronic information systems that maintain electronic protected health information to allow access only to those persons or software programs that have been granted access rights as specified in §164.308(a)(4) [Information Access Management].”

**Operational Specifications**

15.A **Unique User Identification**

1. Each **covered component** of New York University will take reasonable and appropriate steps to ensure that **access** to **EPHI Systems** is granted to **workforce members** using unique user identifiers (i.e., user IDs) that:  
   a. Identify individual **workforce members** (i.e., no redundant user IDs)  
   b. Permit activities performed on **EPHI Systems** to be traced to the individual **workforce member** through the unique identifier

2. Unique user identifiers (i.e., user IDs) shall not give any indication of **workforce members’** privilege levels.

3. New York University and each **covered component** will have a procedure for assigning unique user identifiers (user IDs), which can include any or all of the following, or another appropriate method:  
   a. **Workforce members’** names  
   b. Exclusive numbers (e.g., PIN, password)  
   c. Biometric identification

4. The **EPHI** security officer of each **covered component** shall review and approve the use of any group user identifiers to gain **access** to **EPHI Systems**.

5. **HIPAA REGULATORY INFORMATION**

**CATEGORY:** Technical Safeguards  
**TYPE:** REQUIRED Implementation Specification for Access Control Standard  
**HIPAA HEADING:** Unique User Identification  
**REFERENCE:** 45 CFR 164.312(a)(2)(i)  
**SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE:** “Assign a unique name and/or number for identifying and tracking user identity.”

15.B **Emergency Access Procedure**

1. New York University and each **covered component** of New York University will take reasonable and appropriate steps to establish, implement, and document an **emergency access** procedure delineating the necessary steps to enable **authorized workforce members** to obtain **access** to necessary **EPHI** during a **disaster** or other **emergency**.
2. New York University and each covered component will provide all appropriate workforce members with periodic training and awareness on the emergency access procedure.

3. New York University and each covered component will provide appropriate workforce members with a current copy of the emergency access procedure and keep an appropriate number of copies at a secure off-site location in conjunction with the Disaster Recovery Plan, as set forth in the Disaster Recovery Plan operational specification (see 8.B), and the Emergency Mode Operation Plan, as set forth in the Emergency Mode Operation Plan operational specification (see 8.C).

4. New York University’s EPHI Security Officer and the EPHI security officer of each covered component will be responsible for approving the emergency access procedure as appropriate, updating it from time to time as necessary, and confirming that the procedure appropriately balances the need for emergency access to EPHI during a disaster or other emergency with the need to protect the confidentiality, integrity, and availability of EPHI.

5. HIPAA REGULATORY INFORMATION
   CATEGORY: Technical Safeguards
   TYPE: REQUIRED Implementation Specification for Access Control Standard
   HIPAA HEADING: Emergency Access Procedure
   REFERENCE: 45 CFR 164.312(a)(2)(ii)
   SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE: “Establish (and implement as needed) procedures for obtaining necessary electronic protected health information during an emergency.”

15.C Automatic Logoff

1. When feasible, electronic sessions will be terminated and workforce members will be logged out of EPHI Systems after a number of minutes to be determined by the covered component (e.g., 3/5/10 minutes), requiring the user to be identified and authenticated again in order to regain access and continue the session.

2. New York University’s EPHI Security Officer or the covered component’s EPHI security officer will determine when it is not reasonable or appropriate to implement electronic automatic logoff mechanisms on certain EPHI Systems and will approve equivalent alternative mechanisms (e.g., screen/session locking, screensaver implemented after period of time).

3. New York University workforce members will be instructed to terminate electronic sessions on EPHI Systems when such sessions are completed and to log off from or lock their workstations or other EPHI Systems when their shifts are completed or when they expect to be away from their workstation or other EPHI System for an extended period of time (e.g., for lunch, meetings, breaks).

4. HIPAA REGULATORY INFORMATION
   CATEGORY: Technical Safeguards
   TYPE: ADDRESSABLE Implementation Specification for Access Control Standard
   HIPAA HEADING: Automatic Logoff
   REFERENCE: 45 CFR 164.312(a)(2)(iii)
   SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE: “Implement electronic procedures that terminate an electronic session after a predetermined time of inactivity.”

15.D Encryption and Decryption

1. Based on its risk analysis, New York University shall determine when to implement encryption for EPHI and EPHI Systems and the type and quality of the encryption algorithm and cryptographic key length.

2. New York University’s EPHI Security Officer and the EPHI security officer of the covered component, based on the results of the risk analysis, shall approve the encryption mechanism used.
3. When encryption is used, New York University and each covered component shall:
   a. protect its cryptographic keys against modification and destruction, and protect its private keys
      against unauthorized disclosure.
   b. implement a documented process for managing the cryptographic keys used to encrypt EPHI
      stored or maintained on EPHI Systems.
   c. periodically determine activation and deactivation dates for its cryptographic keys.

4. New York University’s EPHI Security Officer and each covered component’s EPHI security officer shall
   maintain documentation defining when encryption is utilized to protect EPHI stored or maintained on
   EPHI Systems, and how such encryption is implemented.

5. HIPAA REGULATORY INFORMATION

   CATEGORY: Technical Safeguards
   TYPE: ADDRESSABLE Implementation Specification for Access Control Standard
   HIPAA HEADING: Encryption and Decryption
   REFERENCE: 45 CFR 164.312(a)(2)(iv)
   SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE: “Implement a
   mechanism to encrypt and decrypt electronic protected health information.”

Policy Definitions

Access
Availability
Business associate
Confidentiality
Covered component
Cryptographic key
Disaster
Electronic Protected Health Information (or EPHI)
Emergency
Encryption
EPHI systems
HIPAA Security Regulations
Integrity
Workforce member
Workstation

Related HIPAA Documents

HIPAA Policy 1 – Overview: Policies, Procedures, and Documentation
HIPAA Operational Specification 2.A – Risk Analysis
HIPAA Policy 5 - Information Access Management
HIPAA Operational Specification 5.B - Access Establishment and Modification
HIPAA Operational Specification 8.B - Disaster Recovery Plan
HIPAA Operational Specification 8.C - Emergency Mode Operation Plan
HIPAA Policy 11 - Facility Access Controls
HIPAA Operational Specification 11.C - Access Control and Validation Procedures
HIPAA Policy 12 – Workstation Use
HIPAA Policy 19 - Transmission Security
HIPAA Operational Specification 19.A - Integrity Controls
HIPAA Privacy Regulations covered component’s Minimum Necessary Policy


