STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

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Guidelines for the Public Release of Public Health Data

I. Introduction

Public health agencies acquire, use, disclose, or store an increasing amount of health-related information about individuals, some of which is highly sensitive, in paper-based and electronic forms for legitimate public health purposes. Uses of health-related information for legitimate public health purposes are critically important to preserving, monitoring, and improving population based health as well as personal health of individuals. Public health agencies have a significant interest in protecting the privacy of health-related information in their possession where protecting the privacy of such information encourages individuals to participate in public health programs and objectives. While public health agencies generally have an excellent record of protecting the privacy interests of individuals in health-related information possessed by the agencies, additional statutory protections will further clarify and protect individual privacy interests while facilitating, without jeopardizing, legitimate public health purposes.[1]

The following guidelines are intended to assist users of public health data in making decisions about the internal and external use and release of public health data, including release to the media and the general public. New Hampshire statutes addressed in these guidelines are listed in Appendix A.

All questions concerning this document should be forwarded to the Health Statistics and Data Management section of the Division of Public Health Services, 29 Hazen Drive, Concord, NH 03301, (603) 271-4988. New Hampshire State Statutes, HIPAA regulations, and professional ethical standards require the highest standards of individual confidentiality protection involving any use or release of public health data. These recommendations are intended as guidelines and are designed to satisfy HIPAA and State statutes. Individuals or data set stewards may choose to follow stricter rules and requirements.

Record level data involving personal identifiers will not be released except by formal application and approval. Such data will be released only for approved research and surveillance activities. Record level data may also be accessed as required for public health surveillance within the Department of Health and Human Services (DHHS) to specially designated employees required to perform these functions.

Aggregated data and public use data sets may be released to the public if such data is sufficiently aggregated to prevent constructive identification.

Data should not be released at a level of detail that is inappropriate for the intended use, even when rules of confidentiality are otherwise satisfied. In particular, statistical suppression rules should apply when numbers are too small to produce reliable statistics (See Section VIII for more information).

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1 Model State Public Health Privacy Act (as of August 1999)
http://www.publichealthlaw.net/Resources/ResourcesPDFs/modelprivact.pdf

Any requests for data that fall outside the criteria set forth in these guidelines, including information requested related to anticipated legal action, should be made only after consultation and approval by counsel for the Division of Public Health Services or other legal representation from the Office of Operations Support, Legal Services Unit.

II. Definitions and Guidance for Use

Aggregated Data

Aggregated data means data that has been grouped into categories. For example, data reported by year, age group, gender, and diagnosis group.

Aggregated Disease Group

Aggregated disease group means grouping of diseases that are commonly used by national organizations to report diseases by putting together related diagnosis or cause of death codes to create logical disease groups. It is recommended that such aggregations be used whenever possible, both to improve credibility as compared to designing custom disease groups, and to decrease the risk of constructive identification, which may be possible if exact diagnosis or cause of death codes are reported.

Direct Identifier

Direct identifier means data elements that may be used to discover the identity of individuals. The following list is not exhaustive, but includes the most common direct identifiers:

- Names
- Postal address information (other than town or city, county, state, and zip code)
- Telephone and fax numbers
- Electronic mail addresses
- Social security numbers
- Certificate and license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Personal Internet IP addresses and URLs
- Biometric identifiers, including finger and voice prints
- Personal photographic images

Confidential Data

Confidential data means all public health data unless it is sufficiently de-identified and/or aggregated to reasonably prevent identification of individuals.

Constructive Identification

Constructive identification means the use of data without direct identifiers to identify individuals. This process usually requires combining information from more than one source. The potential for using data without direct identifiers to constructively identify individuals increases with the amount of information given (such as specific diagnosis codes, age, sex, year, limited geographic area, etc.), and with small numerators and denominators (for example: 1 out of 10 individuals). There is also risk of constructive identification if the denominator is small and the numerator is nearly the same size as the denominator (for example: 98 out of 100 individuals). This risk is reduced with larger denominators.

Health Information

Health information, as defined by HIPAA Privacy/Security/Enforcement regulations:
"any information, whether oral or recorded in any form or medium, that: (1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and (2) relates to the past, present, or future physical or mental health or

condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual." (45 CFR §160.103).

Institutional Review Board

Institutional review board means any board, committee, or other group formally designated by an institution authorized under federal or state law to review, approve the initiation of, or conduct periodic review of research programs to assure the protection of the rights and welfare of human research subjects, consistent with requirements of the Federal Policy for the Protection of Human Subjects. (http://www.hhs.gov/ohrp/humansubjects/commonrule/index.html)

Limited Use Data Sets

Limited use data sets are record level data sets containing confidential data that do not contain direct identifiers, but can contain information where constructive identification is potentially an issue.

Limited Use Data Tables

Limited use data tables are aggregated data that contain information where constructive identification is potentially an issue (i.e., due to reporting of information in cells that typically would be suppressed to prevent constructive identification).

Public Use Data Set

Public use data set means record level data prepared by data stewards with the intent of making them available for public use. Public use data sets are de-identified. They do not contain direct identifiers and are designed with an expectation they cannot be used for constructive identification. A public use data set must have one version per time period covered by the data. Public use data files fall outside of the Code of Federal Regulations (CFR) for the Protection of Human Subjects, once they have been appropriately classified as public use data sets.

Public Health Practice

Public health practice is the collection and analysis of identifiable health data by a public health authority for the purpose of protecting the health of a particular community, where the benefits and risks are primarily designed to accrue to the participating community (CSTE).

Public Health Research

Public health research is the collection and analysis of identifiable health data by a public health authority for the purpose of generating knowledge that will primarily benefit those beyond the participating community who bear the risks of participation (CSTE). Research, as defined in 45 CFR 46, means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of these guidelines, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Record Level Data

Record level data means a set of data made up of individual records of events (e.g., individual hospital stays, cancer diagnoses, births) and/or further detail within those events (e.g., individual claim lines in a hospital stay). This data is highly confidential if it includes direct identifiers.

Surveillance

Surveillance means the ongoing systematic collection, analysis and interpretation of outcome-specific data and the provision of such information, which leads to action being taken to prevent and control a disease.

III. Release of Confidential, Record Level, Data Including Personal Identifiers

Researchers

Researchers and individuals doing public health surveillance, who require record level data, and are not authorized DHHS public health data users or contractors must demonstrate the need for such information by submitting a request for confidential data and obtaining approval from the DHHS/DPHS data stewards. A release of any data requested will proceed only after the requestor has signed an assurance statement and is conditioned upon the researcher maintaining confidentially of all released information. Different data sets have different processes for release of information containing direct identifiers, with the HIPAA requirement of approval by an institutional review board or privacy board providing the minimum benchmark for release.\

Access to record level data is restricted to investigators with approved studies. Collaborating investigators will have access to records and fields approved in their research application.

Use of record-level data does not require application for release of confidential data if the user is authorized by DHHS to conduct public health surveillance or research. Such data use is allowed under HIPAA regulations and state law. In the case of vital records data, access for DHHS authorized users is covered under the Memorandum of Understanding between the Department of Health and Human Services and the Department of State/Division of Vital Records Administration.

Individuals Requesting Their Own Information

Individuals requesting their own personal information collected under HIPAA or New Hampshire public health statute or administrative rule shall receive such information after providing public health officials with sufficient evidence of their identity. Sufficient evidence may include, but is not limited to, copies of driver's licenses, birth certificates, or a notarized letter.

Governmental Authorities

New Hampshire public health officials or other New Hampshire agency officials may receive personal information in instances where the case(s) resides in their jurisdiction, where there is responsibility for specific client services (i.e. disease control or case management activities), provided the information requested is essential to a public health purpose, or where required by law. The release of any personal information is conditioned upon the requestor maintaining the confidentiality of the information.

IV. Release of Non-Confidential Aggregated Data

Guidelines

It is desirable to have rules for privacy protection which consider both denominator size and numerator size.

The Health Statistics Section recommends the following guidelines to prevent constructive identification. These guidelines include a rule to increase flexibility when doing aggregations.

1. Include at least one year of data
2. Aggregate to at least 5-year age groups
3. Group disease, cause of death, or other health indicators according to nationally accepted groupings (CDC, NCHS, etc.)
4. Include at least 5000 in the total denominator (across all age and gender groups)
5. Combine both genders in the aggregation

Flexibility is added to these guidelines by using the "Rule of Ones". This rule assigns a "1" to each of the six aggregation rules presented above. If a finer aggregation is required, a number less than "1" is assigned. If a higher level of aggregation is used, then a number larger than "1" is assigned. As long as the product of all 5 rules is equal to or greater than "1", aggregation is sufficient. If the product is less than "1", aggregation may be insufficient and constructive identification may be possible. Below are examples of calculations using the "Rule of Ones."

Example 1	
One year	1
5-year age groups	1
Aggregated disease groups	1
Populations of 5,000	1
Total both genders	1
Product of 5 terms = 1: Satisfactory	1

Example 2	
By month	1/12
5-year age groups	1
Aggregated disease groups	1
Populations of 5,000	1
By gender	½
Product of 5 terms <1: Not Satisfactory	1/24

Example 3	
5 years	5
10-year age groups	2
Aggregated disease groups	1
Populations of 10,000	2
Total both genders	1
Product of 5 terms > = 1: Satisfactory	**10**

As an additional guideline, avoid reporting race/ethnicity if the subgroups involve excessively small numbers, perhaps less than 100.

If aggregated data does not satisfy the rule of ones but the risk of constructive identification appears low, it is recommended that numerators between 1 and 4 events are suppressed. If there are doubts that releasing the data, even with numerator suppression, risks constructive identification, a confidential data use agreement may be recommended or required.

In Summary: The following practices can help assess and reduce confidentiality risks:

- Be cautious when reporting rates or ratios based on denominators less than 300 and extremely cautious when denominators are less than 100.
- Be cautious when reporting counts less than 5.
- Be cautious when reporting a specific (confidential) characteristic of a population if a very high proportion of the population has this characteristic.
- When producing multiple tables, be careful that users cannot derive confidential information through a process of subtraction.

V. Release of Non-Confidential, Public Use Data Sets

Public use data sets may require different levels of suppression and/or aggregation than for custom data requests because custom requests can be designed to provide more detail in some fields in exchange for less detail in others. For example, a public use data set may provide unique diagnosis codes at the county level, while a custom data request may provide town-level data but with diagnosis codes grouped into categories.

Public use data sets should be produced annually or upon request for data sets that are rarely requested. To eliminate the possibility of constructive identification, only one version of a public use data set should be produced for the time period. Data sets should be produced in accordance with the stricter of either New Hampshire statute or rule, or the department's interpretation of HIPAA standards for de-identification of data sets by presenting health information with potentially identifying information modified in one of two ways.

The typical method is to remove the following identifiers of the individual or of relatives, employers, or household members of the individual:

- Direct identifiers;
- All geographic subdivisions smaller than a State, except county or public health regions;
  - All elements of dates (except year and day of week) for dates directly related to an individual, including birth date, admission date, discharge date, date of death, and date of diagnosis;
  - All ages over 89 except that such ages and elements may be aggregated into a single category of age 90 or older.

HIPAA allows data stewards with sufficient expertise to design their own de-identified data sets. See section 164.514 of the privacy rule for more information.

VI. Limited Use Data Sets

Individuals requesting the release of limited data sets and tables for research must do so in accordance with NH RSA 91-A: 10 unless there is other controlling statute or rule for the data in question (see appendix) to requestors for the purposes of research under the following conditions:

i. The requestor submits a written application that contains:

1. The following information about the principal investigator in charge of the research:
   a. name, address, and phone number;
   b. organizational affiliation;
   c. professional qualification; and
   d. name and phone number of principal investigator's contact person, if any.
2. The names and qualifications of additional research staff, if any, who will have access to the data.
3. A research protocol which shall contain:
   a. a summary of background, purposes, and origin of the research;
   b. a statement of the general problem or issue to be addressed by the research;
   c. the research design and methodology including either the topics of exploratory research
   d. or the specific research hypotheses to be tested;
   e. the procedures that will be followed to maintain the confidentiality of any data or copies of records provided to the investigator; and
   f. the intended research completion date.
4. The following information about the data or statistical tables being requested:
   a. general types of information;
   b. time period of the data or statistical tables;

c. specific data items or fields of information required, if applicable;
d. medium in which the data or statistical tables are to be supplied; and
e. any special format or layout of data requested by the principal investigator.

ii. The requestor signs a ""Data Use Agreement" signed by the principal investigator that contains the following:
1. Agreement not to use or further disclose the information to any person or organization other than as described in the application and as permitted by the Data Use Agreement without the written consent of the agency.
2. Agreement not to use or further disclose the information as otherwise required by law.
3. Agreement not to seek to ascertain the identity of individuals revealed in the limited data set and/or statistical tables.
4. Agreement not to publish or make public the content of cells in statistical tables in which the cell size is more than 0 and less than 5 unless:
a. otherwise provided by law; or
b. the information is a public record.
5. Agreement to report to the agency any use or disclosure of the information contrary to the agreement of which the principal investigator becomes aware.
6. A date on which the data set and/or statistical tables will be returned to the agency and/or all copies in the possession of the requestor will be destroyed.

iii. The agency head (or designee) shall release limited data sets and statistical tables and sign the Data Use Agreement on behalf of the state when:
1. The application submitted is complete.
2. Adequate measures to ensure the confidentiality of any person are documented.
3. The investigator and research staff are qualified as indicated by:
a. Documentation of training and previous research, including prior publications; and
b. Affiliation with a university, private research organization, medical center, state agency, or other institution which will provide sufficient research resources.
4. There is no other state law, federal law, or federal regulation prohibiting release of the requested information.

Within 10 days of a receipt of written application, the agency head, or designee, shall respond to the request. Whenever the agency head denies release of requested information, the agency head shall send the requestor a letter identifying the specific criteria which are the basis of the denial. Should release be denied due to other law, then the letter shall identify the specific state law, federal law, or federal regulation prohibiting the release. Otherwise the agency head shall provide the requested data or set a date on which the data shall be provided.

VII. Survey Data Based on a Probability Sample

Sampling

One method of protecting the confidentiality of data is to conduct a sample survey rather than a census. Data collection based upon a sample of persons is protective because the presence of a given person's records is not certain and a respondent who appears to be unique may not be the person he/she is thought to be.

Sampling may lower the disclosure risks from published data depending on the sampling rate, the number and detail of variables tabulated, and whether or not there exists a public listing of the complete population from which the sample is drawn. The sample should also be free of any outlier values such as individuals or establishments with unusual characteristics. The use of sampling methodology does not ensure that the published data are free from disclosure risks and any published tables from a sample should still be reviewed.

Weighting

Survey data that are weighted provide estimates by multiplying respondents' data by a sampling weight and then aggregating all the weighted responses. When data are used to make estimates concerning the population from which a sample is drawn, they are generally adjusted by sample weights that take into account the peculiarities of the sampling procedure. Weighted totals take the place of actual frequencies in published tables. The use of sample weights makes an individual respondent's data less identifiable from published totals when the values of the weights themselves are not disclosed.

Statistical Limitations

Additionally, many agencies require that estimates must achieve a specified level of statistical reliability before they can to be published. Statistical reliability requirements may result in more cells being withheld from publication than would a disclosure limitation rule.

(For more information, please refer to: STATISTICAL POLICY WORKING PAPER 22 (Second version, 2005), Report on Statistical Disclosure Limitation Methodology, Federal Committee on Statistical Methodology Statistical and Science Policy, Office of Information and Regulatory Affairs Office of Management and Budget December 2005, pp 12, 13, 14.)

Recommended Guidelines for Survey Sample Data within DHHS

Rules restricting reporting of data from a survey based on a probability sample should be developed and documented by the survey data steward and should be based on appropriate statistical methods, the sampling design and protection of the confidentiality of survey respondents.

NH Behavioral Risk Factor Surveillance System (BRFSS)

- Frequency or other estimates reported should always be weighted by the appropriate weighing factors.
- Estimates for one or more years, at the state, county, or public health region level, or for Manchester or Nashua, should follow CDC recommendations:
  - Estimates should not be reported when based on denominators of fewer than 50.
  - Estimates with confidence interval half widths of more than 10 percentage points should not be reported.

In addition, HSDM recommends that sample survey estimates having a Coefficient of Variation (CV) of more than 30% should either not be reported or should be noted in an analysis report as statistically unreliable (CV = the ratio of the standard error of the estimate divided by the estimate and expressed as a percent).

For reporting of data below the level of county, public health region, or Manchester and Nashua, HSDM should be contacted for guidance on protection of confidentiality and appropriate statistical methods.

VIII. Statistical Guidelines for the Release of Data

The Health Statistics section of the Division of Public Health Services provides the following guidelines when working with traditional administrative data sets and should not be interpreted to restrict access to information. They may not apply to specific data sets where data collection unavoidably results in very small numbers.

Statistical suppression rules should apply when numbers are too small to produce reliable statistics. The National Center for Health Statistics suppresses all rates and percentages that consist of fewer than 20 numerator

events. The reason for this rule is that at 20 events in the numerator, the width of the associated confidence interval is as wide as the statistic itself. For example, a rate of 200 per 100,000 based on a numerator of 20 and a denominator of 10,000 has a 95% CI extending from 100 to 300. If a numerator is less than 20 events, the confidence interval is even wider. Because of the uncertainty of these statistics, it is not appropriate to use statistics based on small numerator values to compare geographic areas or monitor trends. Furthermore, confidence intervals do not quantify additional uncertainty that may be present due to biases in the data such as data quality errors.

Therefore, no data should be released that will be used to produce rates or percentages unless numerators are at least 20. If a customer does not intend to display confidence intervals, it is recommended that data not be released unless numerators consist of at least 100 events. These rules support confidentiality guidelines by assuring that data is not released at a level of detail that cannot be reasonably justified for public health research and surveillance.

How to address the statistical issues

Increase Numerator Size

In preparing a data table for dissemination, it is recommended that analysts first examine the counts in each cell of the table. If rates are desired and the numerator of any cell is less than 20, an effort should be made to increase the size of the numerator. (Use of 20 events as the threshold for reliability is consistent with standard CDC practice.) Techniques to accomplish this include the following:

- Combine multiple years of data,
- Collapse data categories, and/or
- Expand the geographic area under consideration.

Include Confidence Intervals

The inclusion of confidence intervals for rates is strongly recommended regardless of the number of health events, but it is especially important when the count is less than 20. Generally, rates with fewer than 20 events in the numerator have very wide confidence intervals. For example, an infant death rate of 10 per 1,000, based on 20 deaths out of a population of 2,000 live births, has a Poisson-based 95% confidence interval between 6 and 15. Clearly, this is not very precise information and users of the data need to know this.

In instances where it is not feasible to incorporate confidence intervals into a data table (which may be the case with many routinely produced, large data tables), it is recommended that analysts:

- Always report the numerator on which the rate is based and
- Include a footnote indicating that rates based on fewer than 20 events are likely to be unstable and imprecise.

Suppress Rates

Suppress rates based on very small numbers (i.e., fewer than 5 health events), reporting only the count (numerator). When rates are suppressed, tables should be constructed such that an indicator (e.g., asterisk) appears in the cell and a legend under the table explains the reason for suppression.

Suppress Confidence Intervals

When rates based on very small numbers (i.e., fewer than 5 health events) are suppressed, confidence intervals should also be suppressed. When confidence intervals are suppressed, tables should be constructed such that an indicator (e.g., asterisk) appears in the cell and a legend under the table explains the reason for suppression.

VIII. General Guidelines for Data Reports

All data released by the Division of Public Health Services in accordance with the above stated guidelines should include the following:

1. The name, title and office contact information of person preparing the data report
2. The date of the report
3. The originating Section and Bureau
4. Identification of data sources

Additionally, release of confidential data provided by DHHS should include the following statement:

"All data in this report are based upon information provided to the New Hampshire Department of Health and Human Services under specific legislative authority. Any release of personal identifying information is conditioned upon such information remaining confidential. The unauthorized disclosure of any confidential medical or scientific data is a misdemeanor under New Hampshire law. Principal researcher shall report to DHHS any use or disclosure of the information contrary to the Data Use Agreement of which the principal investigator becomes aware. DHHS is not responsible for any duplication or misrepresentation of data released in accordance with this guideline."

References and Resources

National Center for Health Statistics, Staff Manual on Confidentiality
http://www.cdc.gov/nchs/data/misc/staffmanual2004.pdf and http://www.cdc.gov/nchs/fastats/default.htm.

Department of Health and Human Services, Centers for Disease Control and Prevention
"Guidelines for Defining Public Health Research and Public Health Non-Research"
http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm

Council of State and Territorial Epidemiologists, Public Health Practice vs. Research, A Report for Public Health Practitioners Including Cases and Guidance for Making Distinctions, May 24, 2004
http://www.cste.org/dnn/ProgramsandActivities/CSTEPublications/tabid/175/Default.aspx

CDC-CSTE Intergovernmental Data Release Guidelines Working Group (DRGWG) Report:
CDC-ATSDR Data Release Guidelines and Procedures for Re-release of State Provided Data (version 12).
http://www.cste.org/dnn/ProgramsandActivities/CSTEPublications/tabid/175/Default.aspx

National Committee on Vital and Health Statistics, Enhanced Protections for Uses of Health Data: A Stewardship Framework for "Secondary Uses" of Electronically Collected and Transmitted Health Data, December 19, 2007,
http://www.ncvhs.hhs.gov/

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Appendix

This appendix is intended to provide a summary of statutory language governing the release of information for these datasets defined by the status of the requestor (i.e. general public, researcher, etc.). The statutes addressed in these guidelines include:

- RSA 91-A: 4 (Right to Know –Access to Public records and Meetings)
- RSA 91-A: 10 (Release of Statistical Tables and Limited Data Sets for Research)
- RSA 126-A: 11 (Medical and Scientific Research Information)
- RSA 126:24 (Bureau of Health Statistics and Data Management and Institutional Review Board) section 126:24-d (this piece actually also covers the HIPAA too)
- RSA 126:25 (Health Care Data) section 126:28
- RSA 130A (Lead Screening Data)
- RSA 420 (Claims Data)
- RSA 141-B (Chronic Disease Prevention) section 141-B: 9
- RSA 141-C (Communicable Disease) section 141-C: 10.
- RSA 141-F (Human Immunodeficiency Virus Education, Prevention, and Control) section 141-F: 8
- Health Insurance Portability and Accountability Act (HIPAA)

Researchers and individuals requesting vital records data will also need to be approved by the DHHS/Secretary of State Division of Vital Records Administration Institutional Review Board (IRB), as established under RSA 126:24.

Statutory Standards Matrix

REQUESTER OF INFORMATION	STATUTE	INFORMATION THAT CAN BE RELEASED
Member of General Public	Health Statistics and Data Management and Institutional Review Board RSA 126:24	Information that is of a "public nature" may be released to properly qualified members of the public with a legitimate interest. Information needed for determination or protection of a personal or property right.
	Health Care Data RSA 126:25	To the public upon request, provided that individual patients or health care practitioners shall not be directly or indirectly identified.
	Chronic Disease Prevention RSA 141-B	Information which does not disclose the identity of an individual and which cannot be used to surmise an identity are available to the public under RSA 91-A.
	Communicable Disease RSA 141-C HIV RSA 141-F	Information which does not disclose the identity of an individual and which cannot be used to surmise an identity are available to the public under RSA 91-A.
Researcher	Bureau of Health Statistics and Data Management and Institutional Review Board RSA 126:24	The Commissioner may authorize the disclosure of personal identifying information for the purposes of health-related research to individuals and institutions demonstrating a need for such information. The requester must submit a research-related health data review request and obtain approval from the Health Statistics and Data Management Health Data Review Committee or Vital Records IRB. However, research conducted using information relative to RSA 141-B and RSA 141-C must be deemed "essential." Any release of information is conditioned upon personal identities remaining confidential.
	Health Care Data RSA 126:25	
	Chronic Disease Prevention RSA 141-B	
	Communicable Disease RSA 141-C HIV RSA 141-F	

REQUESTER OF INFORMATION	STATUTE	INFORMATION THAT CAN BE RELEASED
New Hampshire public health official	Health Care Data RSA 126:25	Same as general public (above)
	Chronic Disease Prevention RSA 141-B	Reports provided to the cancer registry which disclose the identity of an individual only if a need which is essential to health-related research is demonstrated and only conditioned upon the personal identities remaining confidential
	Communicable Disease RSA 141-C HIV RSA 141-F	All information, including personal identifying information, where the case(s) resides or where there is responsibility for specific client services (i.e. disease control or case management activities) provided the information requested is essential to the health care needs of that client or protecting the health of the public, conditioned upon the personal identities remaining confidential