CHAPTER 17

Privacy

POLICY 17.01 • Right to Privacy

PRIVACY • POLICY 17.01

Right to Privacy

It is the policy of the Practice to maintain the privacy and security of all individually identifiable health information for all patients. The Practice provides notice to all Practice patients who arrive for appointments, informing them of their right to privacy of their protected health information (PHI). This policy describes procedures implemented by the Practice to ensure the privacy of PHI. The Practice obtains acknowledgment of receipt of such notice.

PROCEDURES

1. A designated privacy officer is appointed from within the Practice to oversee the policies and procedures to ensure that patients' rights to privacy are fulfilled.
2. All patients arriving for care receive a Notice of Patients' Privacy Rights (see below) and the Practice's Receipt of Notice of Privacy Practices Written Acknowledgment Form (see below). All patients are asked to sign the acknowledgement of receipt form.
3. The Practice website contains the privacy notice, privacy practices, and the acknowledgment response.
4. The Practice obtains written acknowledgment from the patient or legal guardian prior to engaging in treatment, payment, or health care operations.
5. Patients may request an accounting of certain non-routine disclosures of their PHI. The request may be a time period not longer than six years and may not include dates prior to April 14, 2003, as stated in the request for an accounting of certain disclosures for non-treatment, payment, or health care operations (TPO) purposes.
6. The Practice obtains written authorization for use or disclosure of PHI in connection with research and marketing.
    a. When appropriate, the Practice uses a combined informed consent authorization form, especially as it relates to patients participating in research studies.
7. The Practice discloses only the minimum PHI to requesting entities and insurance companies in order to accomplish the intended purpose.
8. As a covered entity, the Practice fully complies with the Privacy Rule of the Health Insurance Portability Accountability Act of 1996 (HIPAA), effective 4/14/2003.
9. The Practice provides the patient, in the Notice of Privacy Practices, a clear, written explanation of how the covered entity may use PHI.
10. Patients will be asked to sign written acknowledgment of the receipt and review of the Notice of Privacy

Practices.

11. Patients are provided access to their medical records and receive copies upon completing a Request to Inspect and Copy Protected Health Information (see below). If the Practice is unable to provide copies based upon the HIPAA guidelines, written notice, in the form of the Patient Denial Letter (see below), is provided to the patient.

12. Patients are given the opportunity to request a correction or amendment to their PHI by completing the Request For Correction/Amendment of Protected Health Information (see below). Any allowed amendments must be in a written amendment; no changes are made directly to the medical record. The Practice must inform patients that a written request for a correction or amendment is required, and that the patient is required to provide a reason to support the requested change.The amendment is accepted or denied in a provider's written response, on a Disposition of Amendment Request (see below).

13. Anyone who feels the confidentiality of a patient's PHI has been violated may submit a Patient Complaint Form (see below) to the privacy officer. Complaints are kept confidential and no repercussion may occur due to the report. Complaints are logged in the Privacy Officer's Incident Event Log (see below).

14. Sanctions are imposed upon employees who violate the privacy of a patient's PHI; sanctions may vary from a warning to termination.

15. All employees of the Practice receive initial and ongoing training on how to prevent misuse of PHI and how to obtain authorization for its use. Employees may use the Privacy Policy Training Checklist and Hipaa Training Log (see below).

16. The Practice secures a Business Associate Agreement (see below) between the Practice and other covered entities that share PHI.

17. The Practice releases no PHI to employers or financial institutions without explicit authorization from the patient or legal guardian.

18. Electronic, physical, and logistical safeguards are implemented to secure the confidentiality of all patients' PHI.

19. The patient may submit a Written Request for Limitations and Restriction of Protected Health Information (see below). Notice of Privacy Practices

The notice of privacy practices is required by the Privacy Regulations created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you or your legal dependent (as a patient of this practice) may be used and disclosed, and how you can access to your individually identifiable health information.

Please Review This Notice Carefully

1. Our commitment to your privacy
   Our Practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain

in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all or your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

2. If you have questions about this notice, please contact:

   The Privacy Officer at: _____

3. We may use and disclose your IIHI in the following ways:

   The following categories describe the different ways in which we may use and disclose your IIHI.

   Treatment. Our practice may use your IIHI to treat you. For example we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including but not limited to, our doctors and nurses—may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

   Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your IIHI to bill you directly for service and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

   Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

   Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

   Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options

or alternatives.

Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians' office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

4. Use and disclosure of your IIHI in certain special circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- ❑ Maintaining vital records, such as births and deaths
- ❑ Reporting child abuse or neglect
- ❑ Notifying a person regarding potential exposure to a communicable disease
- ❑ Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- ❑ Reporting reactions to drugs or problems with products or devices
- ❑ Notifying individuals if a product or device they may be using has been recalled
- ❑ Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- ❑ Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- ❑ Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.

- ❑ Concerning a death we believe has resulted from criminal conduct.
- ❑ Regarding criminal conduct at our offices.
- ❑ In response to a warrant, summons, court order, subpoena or similar legal process.
- ❑ To identify/locate a suspect, material witness, fugitive or missing person.
- ❑ In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity or location of the perpetrator).

Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain written authorization to use your IIHI for research purposes except when Internal Review Board of Privacy Board has determined that the waiver of your authorization satisfies the following:

(i) the use or disclosure involves no more than a minimal risk to your privacy based on the following:

a. An adequate plan to protect the identifiers from improper use and disclosure;

b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and

c. Adequate written assurances that the IIHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(ii) the research could not practicably be conducted without the waiver; and

(iii) the research could not practicably be conducted without access to and use of the IIHI.

Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the

institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

5. Your Rights Regarding Your IIHI

You have the following rights regarding the IIHI that we maintain about you:

Confidential Communication. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written to the Privacy Officer at:_____specifying the requested method of contact and/or the location where you wish to be contacted. Our practice will accommodate *reasonable* requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to _____. Your request must describe in a clear and concise fashion:

- ❑ the information you wish restricted;
- ❑ whether you are requesting to limit our practice's use, disclosure or both; and
- ❑ to whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: _____ in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: _____. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and correct; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for

non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented (for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim). In order to obtain an accounting of disclosures, you must submit your request in writing to: _____. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: _____.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: _____. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time ***in writing***. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note we are required to retain records of your care.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer at: _____.Business Associate Agreement

THIS AGREEMENT is executed this ___day of _____, 20__, by _____, Hereinafter referred to as "Business Associate" and _____, hereinafter referred to as "Covered Entity."

SECTION 1
Definitions

1.1 "Business Associate" shall mean _____ BUSINESS ASSOCIATE

1.2 "Covered Entity" shall mean _____PRACTICE NAME COVERED ENTITY

1.3 "Individual" shall have the same meaning as the term "individual'' in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

1.4 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

1.5 "Protected Health Information" shall have the same meaning as the term "protected health information'' in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.6 "Required By Law" shall have the same meaning as the term "required by law'' in 45 CFR 164.501.

1.7 "Secretary" shall mean the Secretary of the Department of Health and Human Services or designee.

SECTION 2
Obligations and Activities of Business Associate

2.1 Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.

2.2 Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

2.3 Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.4 Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement.

2.5 Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

2.6 Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual.

2.7 Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

2.8 Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

2.9 Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information.

2.10 Business Associate agrees to adopt and implement reasonable and appropriate administrative, physical and technical safeguards that are necessary to protect the confidentiality and integrity of PHI.

2.11 Business Associates agrees to report security incidents to the covered entity.

2.12 Business Associate agrees to implement reasonable and appropriate necessary safeguards to protect PHI.

SECTION 3
Permitted Uses and Disclosures by Business Associate
General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in [Insert Name of Services Agreement between Practice and Business Associate], provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity.

SECTION 4
Obligations of Covered Entity

4.1 Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR 164.520, as well as any changes to such notice.

4.2 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed.

SECTION 5
Term and Termination

5.1 Term.
The Term of this Agreement shall be effective as of [Insert Effective Date], and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

5.2 Termination for Cause.
Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. Covered entity may terminate this and any other Agreement between Covered Entity and Business Associate if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity. In addition, Covered Entity may immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

5.3 Effect of Termination.

(1) Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(2) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

SECTION 6
Miscellaneous

6.1 Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.

6.2 Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

6.3 Survival. The respective rights and obligations of Business Associate shall survive the termination of this Agreement.

6.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.

BUSINESS ASSOCIATE	COVERED ENTITY
By:_____	By: _____
Signature: _____	Signature: _____Title:
_____	Title: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of the Notice of Privacy Practices.

Signature of Patient:_____ Date: _____

Signature of Guardian: _____ Date: _____

REQUEST FOR AN ACCOUNTING OF CERTAIN DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR NON-TPO PURPOSES

As a patient, you have the right to receive an accounting of certain non-routine disclosures of your identifiable health information made by our practice for non-TPO purposes. Your request must state a time period that may not be longer than six (6) years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be provided free of charge. For additional lists during the same 12-month period, you may be charged for the costs of providing the list; however, the practice will notify you of the cost involved and you may choose to withdraw or modify your request.

To request an accounting of disclosures for non-TPO purposes made by the practice, you must submit your request in writing to the Privacy Officer at: _____

Patient Name: _____

Date of Birth: _____

Patient Address:

Street: _____

Apartment number: _____

City, State, Zip: _____

Signature of Patient:_____ Date: _____

Signature of Guardian: _____ Date: _____

Printed Name of Legal Guardian: _____

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Address:

Street: _____

Apartment number: _____

City, State, ZIP: _____

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $_____ per page, with a minimum charge of $_____.

Signature of Patient:_____ Date: _____

Signature of Guardian: _____ Date: _____

Printed Name of Legal Guardian: _____

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Address:

Street: _____

Apartment number: _____

City, State, ZIP _____

Type of PHI to be restricted or limited: (Please check all that apply.)

- ❑ Home phone #
- ❑ Home address
- ❑ Occupation
- ❑ Name of employer
- ❑ Visit notes
- ❑ Hospital notes
- ❑ Prescription information
- ❑ Patient history
- ❑ Office address
- ❑ Office phone #
- ❑ Spouse's name
- ❑ Spouse's office phone #
- ❑ Other: _____

How would you like to use and (or disclosure of) your PHI restricted?

_____

_____

_____

Signature of Patient:_____ Date: _____

Signature of Guardian: _____ DATE: _____

Printed Name of Legal Guardian: ____

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Address:

Street: _____

Apartment number: _____

City, State, ZIP: _____

Type of Entry to be amended:

- ❑ Visit note
- ❑ Nurse note
- ❑ Hospital note
- ❑ Prescription information
- ❑ Patient history
- ❑ Other

Please explain how the entry is inaccurate or incomplete:

_____
_____
_____

Please specify what the entry should say to be more accurate or complete:

_____
_____
_____

Signature of Patient:_____ Date: _____

Signature of Guardian: _____ Date: _____

Printed Name of Legal Guardian: _____

DISPOSITION OF AMENDMENT REQUEST

Patient Name: _____

Date of Birth: _____

Patient Address:

Street: _____

Apartment number: _____

City, State, ZIP: _____

Date of Amendment Request _____

Amendment has been:

- ❑ Accepted
- ❑ Denied
- ❑ Denied in part, Accepted in part

If denied (in whole or in part)*, check reason for denial:

- ❑ PHI was not created by this organization
- ❑ PHI is not available to the patient for inspection in accordance with the law
- ❑ PHI is not a part of patient's designated record set
- ❑ PHI is accurate and complete

Comments from healthcare provider who provided the service:

_____

_____

Name of Employee completing form: _____
Title: _____
Signature of Treating Provider:_____
Date:_____

* If your request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to the practice, Attn: Privacy Officer: _____

If you do not provide us with a statement of disagreement, you may request that we provide you with copies of your original request for amendment, our denial, and any disclosures of the protected health information that is the subject of the requested amendment. Additionally, you may file a complaint with our Privacy Officer at: _____, or the Secretary of the U.S. Department of Health & Human Services.

PATIENT COMPLAINT FORM

Our practice values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care.

If the Practice staff has fallen short of this goal, we want you to notify us. Please be assured that your complaint will be kept confidential. Please use the space provided below to describe your complaint. It is our intent to use this feedback to better protect your rights to patient confidentiality.

_____
_____
_____
_____
_____
_____
_____
_____

Name of Patient _____
Date_____
Signature of Patient _____
Phone Number_____

PRIVACY OFFICER'S INCIDENT EVENT LOG

Date Received	Date Investigation Complete	Nature of Complaint	Results of Investigation	Sanctions

PRIVACY POLICY TRAINING CHECKLIST

Training conducted on date: _____ by: _____

Training included: (Please check next to the action item to indicate training completion.)

_____ Introduction to HIPAA and the Privacy Rule

_____ Introduction of Privacy Officer and Overview of Privacy Officer Responsibilities

_____ Explanation of Workforce Confidentiality Agreements

_____ Overview of Practice's Privacy Policies and Procedures

_____ Overview of Practice's Notice of Privacy Practices

_____ Explanation of Privacy Forms

_____ Patient Authorization Form

_____ Form Requesting Restriction on Uses of Disclosures of PHI

_____ Form to Inspect and Copy PHI and to Implement Access Denial

_____ Form to Amend PHI

_____ Form to Receive Accounting of Disclosures of PHI

_____ Patient Complaint Form

_____ Explanation of Who Can Disclose PHI

_____ Discussion of Job Responsibilities as it relates to PHI

_____ Explanation of Minimum Necessary Standard

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize [Practice Name] to use and/or disclose certain protected health information (PHI) about me to: _____.
Name of entity to receive this information

This authorization permits [Practice Name] to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____
_____
_____
_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on [date]: _____, or defined event.

The Practice will ___ will not____ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officers at:

_____

Signed by: _____
Relationship to Patient: _____
Patient's Name: _____
Date: _____
Print Name of Patient or Legal Guardian: _____

PATIENT DENIAL LETTER

Date: _____

Patient Name: _____

Patient Address: Street: _____

Apartment number: _____

City, State, ZIP: _____

Dear _____:

In accordance with the Final Rule for the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) issued by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Practice is unable to honor your request for the following reason(s):

- ❑ _____does not possess the information requested. (Insert location of PHI if known)
- ❑ You have requested psychotherapy notes, as defined in the Privacy Rule, and we are not required to allow you to inspect and obtain a copy of your psychotherapy notes.
- ❑ The Privacy Rule does not require the practice to permit you to inspect and obtain a copy of the requested information because it has been compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding.
- ❑ The Privacy Rule does not require the practice to permit you to inspect and obtain a copy of the requested information because it is subject to or exempted by the Clinical Laboratory Improvements Amendments (CLIA) of 1988.
- ❑ The Privacy Rule does not require the practice to permit you to inspect and obtain a copy of the requested information because the information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.
- ❑ The Privacy Rule does not require the practice to permit you to inspect and obtain a copy of the requested information because the information was/is being created or obtained in the course of ongoing research that includes treatment and you agreed to the denial of access when you consented to participate in the research. Your right of access will be reinstated upon the completion of the research.
- ❑ The requested information is contained in records subject to the federal Privacy Act, 5 U.S.C.§ 552a, and this denial meets the requirements of that law. (The Privacy Act of 1974 protects personal information about individuals held by the federal government.)
- ❑ A licensed healthcare professional has determined in his or her professional judgment that access to the requested information is reasonably likely to endanger your life or physical safety or the life or physical safety of another person.
- ❑ You are the personal representative of the subject of the requested information, and a licensed healthcare professional has determined, in the exercise of professional judgment, that the requested information should not be provided to you.

If access to requested information has been denied for any of the last three reasons listed above, you have the right to have the denial reviewed by another licensed healthcare professional who did not participate in this denial. If you choose to have this denial reviewed, please submit a written request to our Privacy Officer at:

Name of Privacy Officer: _____

Practice Name: _____

Address: _____

HIPAA Training Log

Staff Name	Date Trained	Trainer	Staff Signature