PRIVACY OFFICER JOB DESCRIPTION

SUMMARY OF DUTIES: THE PRIVACY OFFICER OVERSEES ALL ACTIVITIES RELATED TO THE DEVELOPMENT, IMPLEMENTATION, MAINTENANCE OF, AND COMPLIANCE WITH THE PRACTICE'S POLICIES AND PROCEDURES ADDRESSING PATIENT PRIVACY AND ACCESS TO PATIENT HEALTH INFORMATION AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), ADMINISTRATIVE SIMPLIFICATION (AS) RULES.

EDUCATION: High School diploma or GED required. Completion of college business courses is highly desirable.

EXPERIENCE: Strongly prefer two years of experience in a leadership role in a medical practice environment. Experience implementing government rules and requirements is also desired.

JOB RELATIONSHIPS: Acts as the point of contact on all HIPAA privacy program implementation and compliance questions for the practice. Reports directly to the practice manager or the physician(s).

WORKING CONDITIONS: Works in a typical medical office environment that is sometimes stressful and requires adjustments to plans and procedures. Requires flexibility and commitment**.**

PERFORMANCE REQUIREMENTS: Knowledge of or ability to quickly learn the requirements of the HIPAA rules. Ability to monitor implementation of the requirements and ensure proper training of the physicians and staff. Knowledge of and ability to apply project management and change management principles. Demonstrated organization, facilitation, communication, and presentation skills are greatly desired.

RESPONSIBILITIES:

- ✓ Acts as the practice's point of contact for all patient privacy issues.
- ✓ Oversees the development, implementation, and maintenance of the policies, procedures and guidelines to be compliant with the HIPAA privacy requirements.
- ✓ Establishes methods to periodically audit the practice to reduce vulnerability and risk exposure due to inappropriate attention to privacy policies and procedures.
- ✓ Prepares and presents periodic reports to the practice manager, physician(s) or board on the practice's HIPAA privacy compliance.
- ✓ Oversees, directs, delivers, or ensures the delivery of initial and ongoing privacy training to the practice's physicians, staff, and new employees.
- ✓ Ensures that contractors, business associates, and others who furnish services to the practice are aware of the requirements of the practice for patient privacy.
- ✓ Ensures, develops and maintains procedures for receiving, investigating, and taking appropriate actions on reports of non-compliance with the HIPAA privacy requirements.
- ✓ Ensures development and implementation of privacy policies and programs to encourage employees to identify potential HIPAA non-compliance situations without fear of retaliation or punishment.
- ✓ Ensures establishment of a process for application of sanctions against individuals who fail to comply with the practice's HIPAA privacy policies and procedures.

- ✓ Establishes mechanisms to track access to and protection of patient health information to prevent unauthorized and inappropriate disclosure of private patient information.
- ✓ Initiates and facilitates activities that foster privacy awareness and compliance within the practice.
- ✓ Maintains a list of the practice's Business Associates.
- ✓ Serves as the interface with the Security Officer for the practice on matters that affect patient privacy and security.
- ✓ Oversees the activities involved in all aspects of the release of patient health information, to ensure full coordination and cooperation under the practice policies and procedures.
- ✓ Maintains an up-to-date knowledge of the HIPAA privacy requirements, changes, modifications, and application to ensure that the practice is current in its program.
- ✓ Serves as the point of contact with the Office for Civil Rights, or other legal entities and external organizations involved in reviewing or auditing the practice HIPAA privacy compliance activities.
- ✓ The practice manager, physician(s), or the board may assign other related duties as necessary.

Note: Some of these responsibilities may be outsourced; however, the Privacy Officer is still ultimately responsible for ensuring they are done.

The Privacy Officer for this practice is: _____

NON-DISCLOSURE/CONFIDENTIALITY AGREEMENT

I understand that this practice has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality, safeguard the integrity and availability, and limit the use and disclosure of patient Protected Health Information (PHI) to authorized individuals and entities. I may see or hear other confidential PHI such as treatment and operational information pertaining to the practice that this practice is obligated to maintain as confidential.

As a condition of my employment/contract/affiliation with this practice, I understand that I must sign and comply with this agreement. By signing this document, I understand and agree that:

- I will not use or disclose confidential PHI except as specified in this practice's policies, procedures, and contracts for the performance of my job.
- My personal access code(s), user ID(s), access key(s), and password(s) used to access computer systems or other equipment will be always kept confidential. I will not share them with other individuals.
- I will not access or view any information other than what is required to do my job. If I have any question about whether access to certain information is required for me to do my job, I will immediately ask my supervisor for clarification.
- I will not discuss any information pertaining to the practice in an area where unauthorized individuals may hear such information (for example, in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, and at social events).
- I will not make inquiries about any practice information for any individual or party who does not have proper authorization to access such information.
- I will fulfill my responsibility in keeping the facility secure and will follow all policies and procedures concerning security for PHI, computer systems, and portable devices.
- I will not remove from the site any devices or media unless instructed or authorized to do so.
- Upon termination of my employment/contract/affiliation with this entity, I will immediately return all property (e.g., keys, documents, ID badges, etc.) to the practice.

I agree that my obligations under this agreement regarding PHI will continue after the termination of my employment/contract/affiliation with this practice. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my employment/contract/affiliation with (Practice Name) as well as potential personal civil and criminal legal penalties.

I have read the above agreement and agree to comply with all its terms as a condition of continuing employment.

Signature of Employee/Contract Employee	Date
Print Name	Practice Name

CONFIDENTIAL HEALTH INFORMATION FAX

This transmission contains patient Protected Health Information (PHI) that is required by law to be disclosed and maintained in a secure and confidential manner. Re-disclosure may be prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

To: _____

Office or Organization: _____

Telephone #: _____

Fax #: _____

From: _____

Office of Organization: _____

Telephone #: _____

Fax #: _____

Date: _____ **Time of Fax:** _____ **# of Pages:** _____

☐ **Urgent** ☐ **Reply Required** ☐ **Other**

Remarks: _____

_____

_____

_____

Warning: This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is *STRICTLY PROHIBITED*. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation**.**

CONFIDENTIALITY STATEMENT FOR EMAILS

This practice will add a statement such as the one below to all email communications. PHI will be sent via email only if the patient has requested it and has signed an acknowledgement that the information may not be protected or if a confidential (encrypted) email system is used.

"The materials and information in this email are confidential and may contain Protected Health Information covered under the HIPAA Privacy Rule. If you are not the intended recipient, be advised that any unauthorized use, disclosure, copying, distribution, or action taken in reliance on the contents of this information is strictly forbidden by law. If you have received this email in error, please notify me by reply email and then delete this message. Do not pass any of this information on to anyone else. Thank you for your cooperation."

NOTICE OF PRIVACY PRACTICES – Version 1

OF [NAME OF COVERED ENTITY, AFFILIATED COVERED ENTITIES, OR ORGANIZED HEALTH CARE ARRANGEMENT, AS APPLICABLE]

THIS NOTICE DESCRIBES:

- HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR MEDICAL INFORMATION
- HOW TO EXERCISE YOUR RIGHT TO GET COPIES OF YOUR RECORDS AT LIMITED COST OR, IN SOME CASES, FREE OF CHARGE
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY, OR SECURITY OF YOUR MEDICAL INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION, INCLUDING YOUR RIGHT TO INSPECT OR GET COPIES OF YOUR RECORDS UNDER HIPAA.

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH [ENTER NAME OR TITLE] AT [PHONE AND EMAIL] IF YOU HAVE ANY QUESTIONS.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2022, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain lawsuits, and law enforcement.

Certain ways that your protected health information could be used or disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning with the date we receive the written signed revocation.

You have several rights concerning your protected health information. If you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right of access to inspect and obtain a copy of your protected health information at a limited cost, or, in some cases, free of charge. Psychotherapy notes are an exception to this right. We must verify your identity before allowing the requested access. We are required to allow access or provide the copy within 15 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We are allowed by HIPAA to deny such requests. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to direct the transmission of an electronic copy of protected health information in an electronic health record to a third party. This is limited to the information already available in an electronic format.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if it is necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communication incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to opt out of fundraising communications.
- You have a right to receive a copy of your laboratory test results directly from the laboratory within 30 days of your request or completion of the report, whichever is longer. We will provide results for any test performed in-house. Patients must request results directly from other laboratories (reference or hospital labs) that performed the test.
- You have the right to discuss the notice with a designated contact person listed above.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: _____

Phone #: _____

Fax #: _____

Office for Civil Rights: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on the following date:

_____

NOTE: If you wish to direct protected health information to a third party, when the requested information is not already available in an electronic format, you can request a copy of the information and send it directly to the third party yourself. Otherwise, you may complete a valid authorization for us to send a copy of the information to the third party.

NOTICE OF PRIVACY PRACTICES – Version 2

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our employees may gather information about your medical history and your current health. This notice explains how that information may be used and shared with others. It also explains your privacy rights regarding this kind of information. The terms of this notice apply to health information created or received by PRACTICE NAME and is effective as of DATE.

We are committed to protecting patient privacy. We are required by the Health Insurance Portability and Accountability Act (HIPAA) to provide you with this notice and to make sure that: your identifiable medical information is kept private; you understand our legal duties and privacy practices with respect to medical information about you; the terms of the notice that are currently in effect are followed; and you are notified in the event of a breach of any unsecured protected health information about you. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Uses and Disclosures

We typically use or share your health information in the following ways:

- **Treatment –** we can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Payment –** we can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*
- **Healthcare Operations –** we can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Legal Requirements –** if required by law, such as reporting abuse, public health risks, workers' compensation claims, or responding to a court order.

Other Uses and Disclosures

We are allowed or required to shared your information in other ways that contribute to the public good, such as public health and research. We are required to meet several conditions in the law before we can share your information for these purposes, which may include the following:

- **Public Health and Safety –** we can share health information for situations such as preventing disease, helping with product recalls, or reporting adverse reactions to medications.
- **Support Research –** we can use or share your information for health research.
- **Organ and Tissue Donation –** we can share health information about you with procurement organizations.
- **Medical Examiner or Funeral Director –** we can share health information with a coroner, medical examiner, or funeral director when an individual dies.

All other uses and disclosures require prior authorization. You have the right to receive a copy of the authorization and the right to revoke the authorization at any time.

HIPAA Privacy Rule to Support Reproductive Health Care Privacy

This rule prohibits the disclosure of protected health information related to lawful reproductive health care. We will comply with this rule to protect patient confidentiality by taking the steps below:

- We will not disclose PHI related to reproductive health care for the purpose of investigating or imposing liability on any individual for seeking, obtaining, or providing lawful health care services;
- If requested to disclose PHI potentially related to reproductive health care, we will obtain a signed attestation from the requesting party stating that the disclosure is not for a prohibited purpose; and
- Comply with all applicable state and federal laws regarding the privacy and confidentiality of reproductive health information.

It is the practice's presumption that reproductive health care provided by a person other than us is lawful unless we have actual knowledge that is was not lawful.

Notice Regarding the Use of Technology

We may use electronic software, services, and equipment, including without limitation to email, video conferencing technology, cloud storage and servers, internet communication, cellular network, voicemail, facsimile, electronic health record, and related technology ("Technology") to share Protected Health Information (PHI) with you or third-parties subject to the rights and restrictions contained herein. In any event, certain unencrypted storage, forwarding, communications and transfers may not be confidential. We will take measures to safeguard the data transmitted, as well as ensure its integrity against intentional or unintentional breach or corruption. However, in very rare circumstances security protocols could fail, causing a breach of privacy or PHI.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to assist you.

- **Access to Records**
  - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
  - We will provide a copy or a summary of your health information, within 60 days of your request. We may charge a reasonable, cost-based fee.
- **Request Restrictions**
  - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Confidential Communications**
  - You can ask us to contact you in a specific manner (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Amend Records**
  - You can ask us to correct inaccuracies in your health record. We may say "no" to your request, but we will tell you why in writing within 60 days.
- **Receive a Record of Disclosures**
  - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
  - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Complaints or Questions

If you believe your privacy rights have been violated, you may file a complaint with us by notifying our Privacy Officer, NAME, at PHONE, or by filing a complaint with the US Department of Health and Human Services Office for Civil Rights at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

COURT ORDERS AND SUBPOENAS

HIPAA permits physicians, practices, and other covered entities to disclose patients' medical records in response to a court order without authorization from the patient. However, subpoenas for medical records are not court orders. As a covered entity, you must comply with the Privacy Rule when responding to subpoenas for medical records. The entity is allowed to release information needed as part of its healthcare operations but must limit the information released to the minimum necessary.

Under the Privacy Rule, medical practices and other covered entities must safeguard PHI contained in patients' medical records. The subpoena should be reviewed to determine whether it meets Privacy Rule protections. If it doesn't, HIPAA prohibits disclosure.

Patient Name: _____ Date Subpoena Received: _____

Court Orders

1. Is there a court order?	☐ Yes ☐ No
If yes, HIPAA permits disclosure of the information specifically described in the order.	
2. If there is no court order or authorization, is there a HIPAA-compliant protective order issued by the Court?	☐ Yes ☐ No
If yes, HIPAA permits disclosure of the records. **Utah and Arizona have different provisions.*	

Subpoena Checklist

1. Is the practice properly identified?	☐ Yes ☐ No
If Yes, proceed to question 2. If No, stop here and contact the requestor for clarification.	
2. Is the patient properly identified with at least two identifiers?	☐ Yes ☐ No
If Yes, proceed to question 3. If No, stop here and contact the requestor for clarification.	
3. Does the subpoena/court/administrative tribunal order specify the records needed?	☐ Yes ☐ No
If No, stop here and contact the requestor for clarification.	
4. Is the party requesting the records properly identified?	☐ Yes ☐ No
If Yes, proceed to question 5. If No, stop here and contact the requestor for clarification.	
5. Does the subpoena include a HIPAA-compliant authorization for release of records signed by the patient or patient's representative?	☐ Yes ☐ No
If Yes, send the requested information (minimum necessary). If No, does the subpoena give assurance the requestor has informed the patient they are requesting this information and given the patient sufficient time to object and that no objections have been filed.	☐ Yes ☐ No
If Yes, send the requested information (minimum necessary). If No, communicate to the patient that the information has been requested and that the information will be sent unless the patient files objections within 3 business days.	

Completed by: _____ Date: _____

MODEL ATTESTATION RELATED TO REPRODUCTIVE HEALTH

Instructions

Information for the Person Requesting the PHI:

- By signing this attestation, you are verifying that you are not requesting PHI for a prohibited purpose and acknowledging that criminal penalties may apply if untrue [42 USC 1320d-6].
- You may not add content that is not required to combine this form with another document except where another document is needed to support your statement that the requested disclosure is not for a prohibited purpose [42 CFR 164.509(b)(3) and (c)(iv)].
    - Example: If the requested PHI is potentially related to reproductive health care that was provided by someone other than the covered entity or business associate from whom you are requesting the PHI, you may submit a document that supplies information that demonstrates a substantial factual basis that the reproductive health care in question was not lawful under the specific circumstances in which it was provided [45 CFR 165.502(a)(5)(iii)(B)(3), (C)(2)].

Information for the Covered Entity or Business Associate:

- You may not rely on the attestation to disclose the requested PHI if any of the following is true:
    - It is missing any required element or statement or contains other content that is not required [45 CFR 164.509(b)(2)(ii)].
    - It is combined with other documents, except for documents provided to support the attestation [45 CFR 164.509(b)(3)].
    - You know the material information in the attestation is false [45 CFR 164.509(b)(2)(iv)].
    - A reasonable covered entity or business associate in the same position would not believe the requestor's statement that the use or disclosure is not for a prohibited purpose as described above [45 CFR 164.509(b)(2)(v)].
- If you later discover information that reasonably shows that any representation made in the attestation is materially false, leading to a use or disclosure for a prohibited purpose as described above, you must stop making the requested use or disclosure [45 CFR 164.509(d)].
- You may not make a disclosure if the reproductive health care was provided by a person other than yourself and the requestor indicates that the PHI requested is for a prohibited purpose as described above, unless the requestor supplies information that demonstrates a substantial factual basis that the reproductive health care was not lawful under the specific circumstances in which it was provided [45 CFR 164.502(a)(5)(iii)(B)(3), (C)(2)].
- You must obtain a new attestation for each specific use or disclosure request [89 FR 32976, 33031].
- You must maintain a written copy of the completed attestation and any relevant supporting documents [45 CFR 164.530(j)].

MODEL ATTESTATION REGARDING A REQUESTED USE OR DISCLOSURE OF PHI POTENTIALLY RELATED TO REPRODUCTIVE HEALTH CARE

The entire form must be completed for the attestation to be valid.

Name of person(s) or specific identification of the class of persons to receive the requested PHI. *Example: Name of investigator and/or agency making the request.*
Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure. *Example: Name of Covered Entity or Business Associate that maintains the PHI and/or name of their workforce member who handles requests for PHI.*
Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose protected health information you are requesting. *Example: Visit summary for [name of individual] on [date]; list of individuals who obtained [name of prescription medication] between [date range].*

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check the box):

☐ The purpose of the use or disclosure of protected health information is **not** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ The purpose of the use or disclosure of protected health information **is** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was **not lawful** under the circumstances in which it was provided.

I understand that I may be subject to criminal penalties pursuant to 42 USC 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

Signature of the person requesting PHI: _____ Date: _____

If you have signed as a representative of the person requesting PHI, provide a description of your authority to act for that person.

_____

Note: This attestation document may be provided in electronic format and electronically signed by the person requesting the PHI when the electronic signature is valid under applicable Federal and state law.

AUTHORIZATION FOR RELEASE OF PHI – Version 1

Patient Name: _____ Date: _____

I authorize this facility to use or disclose my health information as described below:

☐ Entire Health Record	☐ Activity Documentation
☐ Admission/Re-admission	☐ Minimum Data Set
☐ Advance Directives	☐ Medication & Treatment
☐ Assessments/Flowsheets	☐ Nursing Documentation
☐ Care Plan	☐ Progress Notes
☐ Informed Consent	☐ Reports from Lab/Diagnostic Test
☐ History – Exams & Records	☐ Face Sheet
☐ Other (Describe as specific as possible:	

Recipient Information:

Name	_____	Name	_____
Address	_____	Address	_____
Phone	_____	Phone	_____
Email	_____	Email	_____

Purpose:

☐ **Initiated at the request of the patient**
☐ **Obtaining my personal records**
☐ **Sharing with other healthcare providers as needed**
☐ **Other:**

Authorization Statements:

- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and HIPAA may no longer protect the information.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.
- This authorization will be in force and effect until: _____

_____ _____

Patient or Representative Signature: Date

_____ _____

Printed Name of Personal Representative (if applicable): Relationship

HIPAA AUTHORIZATION FORM – Version 2

I authorize _____ to use and disclose my following protected health information (PHI) listed below for the purpose(s) listed elsewhere on the page.

Name of entity or person(s) to receive information:

_____ _____

_____ _____

Describe how the PHI will be used or disclosed, such as date of service, type of service, level of detail to be released, origin of information, etc.

This PHI is being used or disclosed for the following purposes *(List specific purposes here):*

_____

_____

_____

_____

This authorization shall be in force and effect until *(specify date or event):* _____, at which time this authorization to use and disclose this PHI information expires. *("End of the research study" and "none" is acceptable for authorization for research purposes*.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (*office address or email address*). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the physician from a third party.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

(Provide a copy of this form to the patient.)

REVOCATION OF AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Revocation of Authorization
This notice revokes the authorization to the use and disclosure of protected health information for:

_____ as signed on: _____

Patient Name (Please Print or Type) Date of Authorization

Effect of Revocation

Protected health information that is collected on or after the date on which this form is received by [Name of Practice] will not be used or disclosed by [Name of Practice] for the purposes specified in the authorization that is revoked.

This revocation of authorization will not limit the ability of [Name of Practice] to seek payment for services that it provided under an earlier authorization, nor to meet legal obligations related to those services, nor will it affect uses or disclosures under the revoked authorization that occurred prior to the effective date of this revocation.

Other consequences of revoking authorization include:

_____

_____

_____

Effective Date of Revocation

This revocation of authorization to use or disclose protected health information is effective on:

_____ (date).

_____
Signature

_____
Name of Patient (Print or Type)

_____ _____
Signature of Patient Date

_____
Signature of Patient or Personal Representative

_____
Relationship of Patient Representative to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of this Office's *Notice of Privacy Practices ("Notice"*), which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office's HIPAA Compliance Officer.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Patient Name (PRINT)

_____ _____
Signature Date

_____
Personal Representative (PRINT) *if applicable*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency, it was not possible to obtain an acknowledgement.

☐ We were unable to communicate with the patient.

☐ Other (*Please provide specific details*):

_____

_____

_____ _____
Employee Signature Date

HIPAA AUTHORIZATION FORM – Version 3

I authorize _____ to use and disclose my protected health information (PHI) listed below upon my request. This includes faxing this information to designated entities or persons.

☐ Appointments ☐ Restrictions ☐ Medications ☐ Released from care

☐ Date of visit ☐ Reason for visits ☐ Diagnosis

Entity or person(s) authorized to receive this information:

☐ School/Daycare/Preschool ☐ Camp ☐ Employer ☐ Social Worker

☐ Personal Representative's Employer ☐ Truant Officer ☐ Parole Officer

☐ Family/Friends

This PHI is being used or disclosed for the following purposes:

☐ Work/school excuse ☐ To verify restrictions ☐ Verify return to work/school

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose this PHI information expires.

☐ No longer in school ☐ Employment terminated ☐ Released from care

☐ Child reaches age of majority

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (*office address or email address*). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Print Name of Patient or Personal Representative | Personal Representative's Authority

(Provide a signed copy of this form to the patient.)

PHOTO AUTHORIZATION FORM

I authorize _____ to use and disclose my protected health information (PHI) listed below.

☐ Take my photograph ☐ Post my photograph where others may view it

Entity or person(s) authorized to receive this information:

☐ Practice staff members only ☐ Practice staff members, visitors and patients

This PHI is being used or disclosed for the following purposes:

☐ Birth announcement ☐ Cavity Free Club ☐ Growth and development

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose this PHI information expires.

☐ No longer in school ☐ Released from care ☐ Child reaches age of majority

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (*office address or email address*). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative	Date
Print Name of Patient or Personal Representative	Personal Representative's Authority

(Provide a copy of this form to the patient.)

AUTHORIZATION TO LEAVE PATIENT MESSAGES (OPTIONAL)

The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care. This includes communicating with patients at their homes, whether through the mail, by phone, or in some other manner. In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual's privacy, covered entities should take care to limit the amount of information disclosed on the answering machine. For example, a covered entity might want to consider leaving only its name and number and other information necessary to confirm an appointment or ask the individual to call back.

A covered entity also may leave a message with a family member or other person who answers the phone when the patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present; however, professional judgment should be exercised.

The HIPAA Privacy Rule also prohibits the practice from using or disclosing patient protected health information (PHI) outside the Notice of Privacy Practice without the authorization of the patient. Messages that contain patient PHI require the patient to sign an authorization form to receive messages by phone, fax, email, voicemail, or any other means by which someone other than the patient might reasonably have access to the message, thereby potentially violating the patient's privacy rights under HIPAA. For example, messages that contain PHI would be test results, medication information, payment information, treatment plans, patient condition information, and anything else that is considered patient condition, treatment, or payment related.

You may elect to have your PHI provided to you by a message from the physician's office by signing this form in the space provided below. Once you have signed the form, future communication with you concerning your PHI may be provided to the designated relative or friend, sent by email, fax or left on your voice mail at the number you provide to this office.

I understand my HIPAA rights and I request that this office, _____ leave messages, including those containing PHI, for me with either the two individuals listed below or by email, fax, or voicemail at the numbers noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information.

_____ _____

Patient Name Date

Relative/Friend:

1. _____ _____

Name Phone

2. _____ _____

Name Phone

_____ _____

Fax # Voicemail

Patient email _____

INVESTIGATION AND RESOLUTION OF COMPLAINT

Date of complaint: _____

Patient: _____ Telephone #: _____

Address: _____

Email: _____

Summary of concern or complaint:

_____

_____

_____

Describe steps taken to investigate:

_____

_____

_____

Date investigation completed: _____

Was the complaint found to be justified? Explain why or why not:

_____

_____

_____

Note: Use back if necessary.

Recommended actions:

_____

_____

_____

Date of contact with person who complained: _____

Contacted by: _____

COMPLAINT

You have the right to file a complaint with us about our privacy practices or our compliance with our Notice of Privacy Practices, our Privacy Policies and Procedures, or federal or state privacy rules or law.

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____

_____

Telephone: _____ Email: _____

PATIENT'S COMPLAINT: Please describe the practice or incident which prompted the complaint.

_____

_____

_____

_____

Please describe why you believe this practice or incident was improper:

_____

_____

_____

_____

This Complaint may be completed on behalf of the patient by a personal representative. I certify that the statements made in this complaint are true to the best of my knowledge.

_____ _____

Patient or Representative Signature: Date

_____ _____

Printed Name of Personal Representative (if applicable): Relationship

YOU ARE ENTITLED TO RECEIVE A COPY OF THIS COMPLAINT.

HIPAA INCIDENT REPORT

Practice Name: _____

Date practice became aware of the incident: _____

Name and title of person who discovered/reported the incident: _____

Name and title of person to whom the incident was reported: _____

Location of the incident: _____

Description of the incident: _____

_____

_____

How was the incident discovered? _____

_____

Which employees, if any, contributed to this incident? _____

_____

Which employees, if any, may have been compromised as a result of this incident? _____

_____

Which patients did this incident affect? _____

_____

Resolution/Corrective Action (if applicable)? _____

_____

Documented by: _____

Date: _____