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| GI FOR KIDS, PLLC |
| HIPAA Privacy Policies and Procedures |

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| [Date] |



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**GIFK**

**Introduction**

**General Policy:** GIFK (GIFK)is committed to protecting the personal, confidential, and privileged information concerning all GIFKpatients at all times. This policy provides guidelines for how GIFKcreates and maintains the necessary policies and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations stipulations there under. All the necessary policies and procedures are created and maintained to protect health information created, acquired, and/or maintained, in compliance with HIPAA standards.

GIFKexpects all practitioners providing healthcare to abide by the Healthcare Notice of Privacy Practices. GIFKpersonnel shall not disclose confidential patient information unless at the patient’s request and/or as authorized by law.

Training shall be provided about privacy and security regulations as they apply to individual duties and responsibilities. Confidential patient information should be discussed with or disclosed to staff on a limited “need to know” basis and only in response to a legal or authorized request. The HIPAA “minimum necessary standard” is strictly enforced.

Team members who have questions regarding patient confidentiality should refer to this policy or consult with GIFK Practice Manager/Administrator. GIFKpolicies are updated as necessary to reflect changes to Federal and State laws, regarding medical record privacy. Breach of patient confidentiality will result in corrective and disciplinary action, including termination of employment, if indicated.

In general, patients can request and are entitled to receive copies or summaries of their records. However the privacy rule contemplates circumstances in which cover entities may deny access to PHI. This may include some mental health patients and some patients being treated for alcohol and drug abuse. Consultation with the physician and approval should be sought prior to release of any part of records.

Staff shall not reveal or disclose proprietary or trade secret information to unauthorized persons. Such proprietary information may relate to GIFKbusiness affairs or the affairs of a vendor or contractor. GIFKstaff shall not reveal or disclose confidential, protected medical staff or peer review information.

All personnel records are considered confidential. Access to personnel files is limited to management, the human resources staff, and authorized, internal auditors. Information system passwords should not be shared. These individuals shall be held accountable for protecting the privacy of personnel records.

**GIFK**

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| **Policy ID:** COMPL- 01 | **Policy Title:** State Law Preemption | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To address how GIFKwill follow the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) unless the State law is more stringent.

**Policy:** GIFKis committed to complying with the HIPAA privacy and security rule that provides privacy protections for individuals’ protected health information (PHI). Nevertheless, if a state law is contrary to this federal regulation and it would be impossible for GIFK to comply with both as a covered entity, GIFKwill comply with the law that provides the greatest privacy rights for the individuals. See 45 C.F.R. Part 160, Subpart B, for specific requirements related to preemption of State law. An unofficial version of the Privacy Rule and the preemption requirements may be accessed at <http://www.hhs.gov/ocr/combinedregtext.pdf>.

**GIFK**

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| **Policy ID:** COMPL- 02 | **Policy Title:** Designated Privacy Official | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To designate an official who will be responsible for development, implementation, and maintenance of GIFKprivacy policies and procedures regarding the use and disclosure of protected health information (PHI) and electronic protected health information (ePHI) in order to comply with HIPAA privacy and security rules.

**Policy:** GIFKPractice Manager/Administrator is responsible for the development and implementation of the privacy policies and procedures of GIFK*.* The Practice Manager/Administrator will oversee the compliance with the privacy and security rules, as well as the implementation and oversight of the HIPAA privacy program within *GIFK .*

The Practice Manager/Administrator is responsible for developing, implementing, and maintaining GIFK’s policies and procedures, regarding the privacy of PHI and ePHI. All policies and procedures must be consistent with GIFK’s HIPAA policies and procedures and all legal requirements, including State laws applicable to the organization. The GIFKPractice Administrator is required to inform team members when the GIFK HIPAA Privacy policies and procedures have been changed or updated to ensure practice-wide compliance with such policies.

To ensure that GIFK’sbusiness practices are compliant with these regulations the Practice Manager/Administrator may conduct evaluations of procedures against the HIPAA Privacy Rule. This individual will, also, receive inquiries and work with other members of the management team to respond to all requests for information from the Department of Health and Human Services (HHS), specifically concerning compliance issues and questions.

As an organizational representative, the Practice Administrator coordinates between all departments within GIFK*,* and provides recommendations to other management officials for resolutions of privacy compliance issues.

**GIFK**

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| **Policy ID:** COMPL- 03 | **Policy Title:** PHI Uses and Disclosures | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To outline the appropriate uses and the proper manner in which all types of protected health information (PHI) are maintained and disclosed.

**Policy:** According to the HIPAA privacy rule, a covered entity is required to put in place reasonable safeguards to protect patient information. GIFK , as a covered entity, shall not use or disclose patient information without a complete and signed authorization for release of Protected Health Information (PHI), except in the circumstances listed by the HIPAA Privacy Rule. The official GIFKform, “Authorization for the Use or Disclosure of Protected Health Information”, is attached as Appendix A. Team members must utilize this form when requested to release PHI.

The HIPAA Privacy Rule has a few exceptions or instances that do not require a covered entity to obtain individual’s authorization when releasing PHI. Those some of those instances are as follows:

* Disclosures required by law
* Disclosures for public health activities when the public health authority is authorized by law to receive reports, such as: controlling disease, birth, death, public health surveillance, FDA device tracking
* Disclosures to a school limited to a proof of immunization of a student or prospective student, and school has obtained and documented agreement from the parent, legal guardian, or the individual, if the individual is an adult or emancipated minor.
* Disclosure concerning victims of abuse, neglect, or domestic violence
* Disclosures for health oversight activities, like audits, investigations, licensures, or disciplinary actions
* Disclosures for judicial and administrative proceedings pursuant to a court or administrative tribunal order or subpoena
* Disclosures about decedents to coroners, medical examiners, funeral directors consistent with the law
* Disclosure for cadaveric organ, eye, or tissue donations
* Disclosures to avert serious threat to health or safety
* Disclosures for specialized government functions like, national security, protective services, State department, etc.
* Disclosures about military personnel to military command authority in limited circumstances.
* Disclosure to due Workers’ Compensation
* Disclosures for law enforcement purposes

There are also exceptions to the treatment, payment, and healthcare operations within HIPAA Privacy Rule. PHI may be used and disclosed by GIFKto carry out essential healthcare treatment, payment, and healthcare operations.

- Health care providers may need to coordinate and manage the care of a patient by consulting other healthcare providers. Referrals may be needed in order to continue and ensure the proper, appropriate care is given to the patient. Through the referral process, the referring physician may have access to all pertinent patient information to provide the necessary continuity of care.

- With regards to payment processing, GIFKmay disclose PHI to other covered entities to obtain payment and reimbursement for the services provided by its’ clients. Health plans may obtain and release patient information to obtain premiums, fulfill coverage responsibilities, or provide reimbursement for the provision of healthcare.

- PHI may also be disclosed for the purposes of essential healthcare operation, such as administrative, financial, legal, and quality improvement activities. These functions are necessary to the proper running of GIFK, and to support core functions of treatment and payment.

Opportunity must be provided to individuals to agree or object to PHI disclosures. They may choose to submit a request to revoke the initial authorization signed, allowing the use and/or disclosure of their PHI. This request must be submitted in writing by using the applicable form, “Individual Revocation of Authorization to Use or Disclose Protected Health Information”, attached as Appendix B.

GIFK may disclose relevant PHI to persons involved in care or payment of the patient, including family, friends, or others identified by the individual patient. GIFKmay notify of patient’s location, condition or death to family, personal representatives, or another responsible for care. This, also, applies to disaster relief efforts. When individuals are not present or incapacitated, such disclosures are permissible using professional judgment to determine if in the best interest of the individual.

**GIFK**

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| **Policy ID:** COMPL- 04 | **Policy Title:** HIPAA Training | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To educate GIFKteam members on HIPAA Privacy and Security Rules’ requirements and regulations as they correlate to specific job functions.

**Policy:** It is the policy of GIFKto require every team member, including PRN and Temporary team members, to be trained regarding their obligations under the Health Portability and Accountability Act of 1996 (HIPAA). Training shall be provided prior to allowing team members to access PHI. This training shall occur at the time of initial orientation with UPAand annually, thereafter. Retraining may take place in the event of updates or changes to HIPAA regulations, or on a needed-basis to ensure compliance with HIPAA regulations. The HIPAA training may take place either in person or via GIFK/UPAapproved, web-based media. A record of each team member’s successful completion of training must be retained in a written or electronic form for a minimum of six years from the date of last training, as well as all training materials utilized. Please see Appendix C for GIFK’s listing of HIPAA Training contained with the “Training Checklist”.

**GIFK**

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| **Policy ID:** COMPL- 05 | **Policy Title:** Minimum Necessary Standard for the Use and Disclosure of PHI | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To provide guidance and ensure team members implement the Minimum Necessary Standard for the use, access to, requests for, and disclosure of protected health information (PHI), required by HIPAA.

**Policy:** GIFKhas set minimum necessary standards to limit the access and use of PHI to the minimum amount necessary to accomplish the intended purpose of use, disclosure, or request. Such disclosures may include routine disclosure of protected health information for the purpose of the treatment, payment, and healthcare operations. GIFKshall make reasonable efforts to limit the uses, disclosures, and requests for disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the particular use, disclosure, or request. This policy is meant to cover all documentation except those covered as exceptions in the Federal HIPAA regulation. These exceptions are outlined, as follows.

Requests for disclosures may be made available to those individuals who are involved in the patient’s care. Yet, precautionary measures are essential to safeguard protected health information. Only those with authorized access will be allowed viewing rights to this information on a need-to-know basis, as it relates to the patient’s medical care and treatment.

The Minimum Necessary Standard does not apply to the disclosures made to the individual patient. Patient authorization may be made by the patient to permit certain uses and disclosures of their PHI to other individuals and/or entities. All items specified within the signed release from the patient will be disclosed by GIFK. This authorization will remain on file within their medical record.

Entire medical records will only be disclosed in accordance with the provisions outlined in this policy. Specific justification must be given as to why the entire medical record is needed and for what purpose. Once access is given to a patient, individual, group of individuals, or a covered entity, the justification for permitting this access will be documented.

The Minimum Necessary Standard does not cover protected health information that is required by law, such as a legal mandate that obligates GIFKto use and/or disclose PHI. Should the U.S. Department of Health and Human Services Office of Civil Rights request PHI from any covered entity for HIPAA compliance purposes, this instance will be considered an except to the Minimum Necessary Standard.

Some disclosures may be made to third parties for the purpose of identifying a patient or notifying a family member or friend about the patient’s condition or death. Such information shall be limited to that, which is in the best interest of the patient. In the case that a team member is a patient of a GIFK it is GIFK’s policy that team members may **not** access their own or any family member’s medical information for any purpose other than those that are required for the team member’s particular job duties.

Authorized GIFKPractice Administrator/management official must review requests from attorneys, subpoenas, and court orders to ensure compliance with applicable State law. This team member will ensure the proper documentation and authorization are present for the release of protected health information. Follow-up with the attorney requesting PHI may be necessary to verify what specific information is needed.

From time to time, some disclosures of PHI may occur that are considered to be non-routine. These disclosures must be reviewed on an individual basis to determine proper compliance with the Minimum Necessary Standard.

**GIFK**

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| **Policy ID:** COMPL- 06 | **Policy Title:** Verification of Identity | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To establish standards for verifying an entity’s or a person’s identity and authority when granting access to PHI.

**Policy:** Prior to disclosing any PHI permitted by the HIPAA Privacy Rule, GIFKshall verify the identity and authority of the person or entity requesting to receive this disclosure. GIFKmust receive proper documentation and authorizations from the person or entity requesting the PHI before any disclosure can be made, if the authority or person is not known. If the HIPAA regulations call for a particular form of identity verification or authorization particular disclosure (e.g. written assurance from research in the case of disclosure of PHI made preparatory to research), then that form is required.

Does this differ with minors?

GIFKpersonnel will accept any relevant evidence that appears reliable and reasonable, considering the circumstances, when verifying a person’s or entity’s identity. Items such as written statements or other similar documentation, verbal statements or other oral declaration from the person making the request for PHI will be accepted, unless there is any justified concern with the evidence provided.

When verifying the identity of personal representatives of patients, these individuals are treated with the same understanding as the patient when releasing PHI. However, PHI will only be disclosed when appropriate justification is provided, the request is within reason, and when the proper documentation has been provided. GIFKwill accomplish this in accordance with the HIPAA Privacy Rule. GIFKreserves the right to reject a personal representative’s authority if, when using professional judgment, the action is believed to be in the patient’s best interest.

Those individuals or entities wishing to request PHI may submit their requests via electronic mail, physical mail, facsimile, and/or in person. All signed requests for documentation must be forwarded to the appropriate records custodian within each department.

**GIFK**

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| **Policy ID:** COMPL- 07 | **Policy Title:** HIPAA Complaints to GIFK | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To impart guidance to team members and patients who wish to file complaints concerning violations of HIPAA policies and procedures within GIFK .

**Policy:** According to the HIPAA Privacy Rule, as a covered entity, GIFK is required to have a process in place to afford individuals the right to file a complaint, have the complaint investigated, and apply resolution to a complaint. It is our policy to maintain a record of all complaints and to investigate all valid complaints to determine the circumstances related to the concerns raised by an individual regarding privacy. If after the investigation it is determined that the individual’s privacy rights have been violated or there is evidence that team members have not adhered to the standards required under HIPAA or GIFKpolicies and procedures, actions may be taken consistent with the HIPAA regulations and our policies and procedures regarding personnel discipline for breach of privacy. No retaliation will be taken against any individual, whether a patient or team member, filing a complaint.

All complaints should be directed to the GIFKpractice administrator/management official and/or UPA Compliance department. These authorized team members will work with the appropriate department officials for assistance with assessment and investigation of all complaints filed. Team members and patients may file privacy complaints by submitting them to the appropriate *GIFK* management official.Individuals filing a complaint should refer to the GIFK “HIPAA Complaint Form”, attached as Appendix D in this manual.

Every effort will be made to maintain the confidentiality and anonymity toward the individual filing a complaint. Privacy complaints must describe in detail the privacy concern, specific details of incident, date incident occurred, and who was believed to have acted inappropriately, if known, with respect to the protected health information in question.

The GIFKpractice administrator /management official will assess each complaint and determine its validity. Should an investigation be warranted, the appropriateGIFKpractice administrator /management official will work with the appropriate department to review any relevant information and documentation related to the complaint. Once all information and documentation have been evaluated, recommendations will be provided, if any sanction or actions need to be taken with respect to the complaint. All complaints received by GIFK *,* whether anonymously or otherwise, are required to be documented and the disposition, recorded if applicable. These records will be retained for six years from the date of initial creation.

**GIFK**

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| **Policy ID:** COMPL- 08 | **Policy Title:** Mitigation & Sanction | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To establish reasonable steps for the mitigation and possible sanctions due to violations of GIFKprivacy and security policies.

**Policy:** Any unauthorized PHI disclosure constitutes a violation of GIFKpolicies and procedures. As required by the HIPAA Privacy Rule, GIFKwill make good faith efforts to mitigate the harmful effects of unauthorized disclosures of PHI. This includes making the damaging effects of the disclosure less severe, partially removing, or correcting the detrimental effects to the most practicable extent. To determine if a breach has occurred, a risk assessment will be performed to determine to what extent, if any, PHI security or privacy has been compromised. Unauthorized individuals who access, use, disclose, attempt to access, and/or assist others in accessing PHI when it is not authorized, will be disciplined or terminated appropriately. GIFK will assign personnel responsible for posting and distributing this policy and all amendments thereto, for the purpose of seeing that team members are aware of its contents.

**Procedure:** While it is the policy of GIFKto mitigate all circumstances concerning known HIPAA violations, each situation is unique and requires a tailored plan to effectively remedy the damages. Each mitigation plan will include the following facets, as appropriate:

Reporting Violations

Each and every report or concern attached to, linked to, or believed to be a HIPAA violation must be promptly reported to the appropriateGIFKmanagement official [and/or Compliance department]. This report can be made directly by calling the Practice management official (865-546-3998), the UPA compliance office at 865-670-6117, and/or anonymously by calling the UPA Compliance Hotline number at 865-305-9283. (Insert website for reporting and form instructions)

Assessment, Investigation, and Mitigation

When a potential breach has been reported, an assessment will be conducted to determine if an investigation must take place. Designated management officials [and/or Compliance department] will investigate to gain a complete understanding of the issue at hand. Identification of the sources of disclosure and/or use of unauthorized protected health information (PHI) is necessary to evaluate the damage and potential harm existing because of this act.

Should the report or concern be warranted, the appropriate GIFKmanagement official will work with UPA Compliance and/orUPAHuman Resources department and the appropriate Legal Counsel to evaluate the immediate and potential threats involved. The following factors must be considered by this group during consultation: whether any damages have occurred; the type and amount of damage, if any; the specific restricted information that was used or disclosed; the reason for the use or disclosure; and how the harm can be mitigated, including but not limited to the notification of the individual (s) who’s PHI was compromised and other reporting as required by HIPAA.

Once mitigation has been determined necessary, the GIFK practice administrator and or UPAwill direct the mitigation actions that follow. The following information must be determined before the mitigation can take place: how, when, and why the problem arose; a review of current policies and procedures; how to correct the problem and prevent a recurrence; what, if any corrective, remedial, or educational action, is appropriate; and whether any other corrective or disciplinary action is warranted, in accordance with current GIFKpolicies and HIPAA guidelines.

Sanctions for team members may include, but are not limited to: re-training, verbal and written warnings, demotion, and termination, in accordance with applicable GIFKpersonnel policies. Managers and supervisors may be sanctioned for failure to satisfactorily instruct their team members, or for failing to identify non-compliance with privacy policies, where reasonable attentiveness on the part of the manager or supervisor would have led to the discovery of problems or violations and provided an opportunity to correct them earlier.

Business Associates

WhileGIFKdoes not have the authority to directly monitor a business associate’s activities, HIPAA violations will require a mitigation plan with the corrective actions to be determined by the appropriate GIFK management officials. If the Business Associate does not adhere to the corrective actions established, GIFKmay choose to terminate the agreement with such entity. All mitigation recommendations are based on HIPAA guidelines and regulations.

\*\*No sanctions or retaliatory actions will be taken against team members who report HIPAA violations. \*\*

**GIFK**

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| **Policy ID:** COMPL- 09 | **Policy Title:** Breach Notification | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To establish protocol for GIFK team members in the event of a breach concerning unauthorized access, use, or disclosure of unsecured protected health information (PHI) and electronic protected health information (ePHI) in a manner not permitted within HIPAA rules and regulations.

**Policy:** Under HIPAA, a covered entity is required to notify individuals of whose unsecured PHI has been accessed, acquired, used, or disclosed without authorization, compromising the security and privacy of the PHI. On the other hand, if the PHI is encrypted, notification is not required.

The following cases are not considered a breach of the privacy and security of PHI:

* + Any unintentional acquisition, access, or use of PHI by a team member or individual acting under the authority of GIFKor a Business Associate with which we have a contract, as long as:
    - Such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of the team member, individual, or Business Associate, and
    - Such information is not further acquired, accessed, used, or disclosed to any person.
  + Any inadvertent disclosure by a person who is authorized to access PHI at a facility operated by GIFK or a Business Associate to another similarly situated person at the same facility, provided that any such information received as a result of such a disclosure is not further acquired, accessed, used, or disclosed by any person.
  + Inadvertent disclosure to an individual(s) that, in the belief of GIFK,would likely have not been able to retain the PHI.

Breach notifications must be presented to individuals affected as soon as feasibly possible, but no later in any case than sixty (60) days following the breach discovery. This notification should include as much of the following as possible: contact information for GIFK, a concise description of the breach, a description of the information that was involved in the breach, the steps affected individuals or parties should take to protect themselves from potential harm, a brief description of what GIFKis doing to investigate the breach, mitigate the harm, and prevent further breaches.

Affected individuals or parties must be informed for the breach as soon as detection of unsecured PHI or ePHI has been discovered. This notice must be in written form, delivered by first-class mail or by email, if the affected party has agreed to receive such notices electronically. If GIFK has insufficient or out-of-date contact information for ten (10) or more individuals or parties, a substitute individual notice must be provided by posting the notice on the homepage of the website for at least ninety (90) days or providing the notice in major print or broadcast media where the affected party is likely to reside. A toll-free phone number must be included and remain in effect for at least ninety (90) days where individuals can learn if their information was involved in the breach. If GIFK has inadequate or outdated contact information for less than ten (10) individuals or parties, a substitute notice may be given through an alternate form of written notice, by telephone, or other means.

It is important to understand that a security incident, involving ePHI, may not always rise to the level of a breach that requires notification under this policy. However, a breach will likely be considered a security incident, if ePHI is involved. For potential breaches involving ePHI, the appropriate GIFKmanagement officials will work with the UPAInformation Systems team and/or UPA Compliance department to determine the best course of action for investigation. Following the discovery of a potential breach, the incident will be investigated and mitigated to the most reasonable extent possible, according to HIPAA rules and regulations.

GIFK Practice administrator/management official and/or UPA Compliance officials must promptly investigate the conduct in question. A risk assessment must be performed to assess whether material violations of applicable laws, rules, or compliance program requirements has occurred. An internal investigation and review of relevant documentation is necessary to determine to what extent the information has been compromised. Designated officials may interview knowledgeable team members and/or Business Associates, as well as the potential privacy/security violators. In some cases, forensic examination of equipment and computer software may be required to determine the extent of potential damage and the precise information that was compromised.

After a complete investigation has been performed, the appropriate *GIFK* practice administrator/management officials [and/or Compliance department] will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed as a result of such breach. The notification should be written in plain language and should include as many of the elements as possible provided within HIPAA regulations: a brief description of what happened, including the date of the breach and the date of the discovery of the breach; a description of the types of unsecured PHI that were involved in the breach, such as full names, social security numbers, date of births, home addresses, account numbers, diagnosis codes, or disability codes; the steps the individuals should take to protect themselves from potential harm resulting from the breach; a brief description of what GIFK is doing to investigate, mitigate, and protect against any further breaches; and contact information for individuals to ask questions or learn additional information the breach, which will include a toll-free number, an email address, website, and/or postal address. This notification will be provided without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach, unless in the case of a Law Enforcement Exception. That exception reads as follows:

If a Law Enforcement Official states toGIFKor its Business Associate that a notification, notice, or posting would impede a criminal investigation or cause damage to national security, GIFKor the Business Associate will: (1) If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the Official; or (2) If the statement is made orally, document the statement, including the identity of the Official making the statement, and delay the notification, notice, or posting temporarily and no longer than thirty (30) calendar days from the date of the oral statement, unless a written statement as described in (1) is submitted during that time.

In the case where a single breach event affects more than 500 residents of the same State or jurisdiction, notice shall be provided to prominent media outlets. *GIFK* will disclose any such breach within sixty (60) days of discovery to the Department of Health and Human Services (HHS) by going through the proper protocol, as outlined by HIPAA regulations. If a breach impacts less than 500 patients, GIFKwill maintain a log notating each occurrence, annually, and submitting the log, every year, to HHS no later than sixty (60) days after the end of the calendar year.

Documentation of alleged violation(s), description of investigation process (to include the objectivity of the investigators and the methodologies utilized), copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, the results of the investigation (e.g. any disciplinary action taken and any corrective action implemented) must remain on file, permanently, in case of future litigation.

**GI For Kids, PLLC**

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| **Policy ID:** COMPL- 10 | **Policy Title:** HHS Investigations | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To establish a protocol on the steps team members must take in the event of a Health and Human Services (HHS) investigation.

**Policy:** The Health and Human Services through the Office of Civil Rights (OCR) may conduct investigations of reported violations of HIPAA. Once the OCR confirms jurisdiction to handle a complaint, an investigation will take place. Such investigations may be conducted by obtaining documentation, staff interviews and/or site visits. In any of these instances, team members must refer these communications and enquiries to the GIFK Practice Administratorto evaluate what appropriate actions should be taken.

**Procedure:** If an OCR notice of investigation is received:

-Notice must be sent to the GIFK Practice without delay.

-GIFK Practice Administrator must notify the proper channels within UPA Compliance Department, seek legal counsel if needed, and work with other members of management and Compliance department to formulate the response requested by the OCR.

-The GIFKPractice Administrator will be the point of contact between GIFKand the HHS representative in the event of an investigation.

**GI For Kids, PLLC**

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| **Policy ID:** COMPL- 11 | **Policy Title:** Business Associate Agreement | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To establish standards for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) relating to GIFK’s Business Associates.

**Policy:** Protected health information (PHI) may be disclosed to a person or entity that enters into a contract or agreement with GIFK, where the uses and disclosures of PHI are outlined and established. These individuals or entities that enter into this agreement are known as Business Associates, when relating to HIPAA regulations. The specific contract discussed above is known as the Business Associate Agreement.

This policy will identify Business Associates and all appropriate contractual requirements in place to govern the use and disclosure of PHI that concern individuals, in conjunction with HIPAA. The Business Associate Agreement serves to provide clarity and understanding toward the use and disclosure of PHI within the Business Associate’s organization on behalf of GIFK*.* For more information concerning GIFK’s “Business Associate Agreement”, please see the attached Appendix E.

Under HIPAA, Business Associates have specific requirements and responsibilities to which they must adhere to remain compliant. All Business Associates and their agents are required to process PHI in accordance with the HIPAA Privacy and Security rules and regulations. Business Associates may only use and disclose PHI as permitted by the Business Associate Agreement and required by law. It is important to note that Business Associates are completely liable under HIPAA rules and are subject to civil and, in some cases, criminal penalties for using and/or disclosing PHI in ways that that are not authorized by its contract or required by law.

In accordance with the HIPAA Security Rule, Business Associates are directly liable and subject to the applicable civil penalties for failing to safeguard electronic protected health information (ePHI). It is the responsibility of GIFKto ensure valid Business Associate Agreements are executed properly, the agreement is in writing, and specific language is used to be HIPAA compliant.

There are specific instances where individuals or entities would not be classified as a Business Associate, by HIPAA’s standards. While the policy above does not apply in the following cases, the applicable HIPAA standards remain in effect:

1. The transmission of ePHI byGIFK, a covered entity, to a health care provider concerning the treatment of an individual;
2. The transmission of ePHI by a group health plan, HMO, or health insurance issuer on behalf of a group health plan to a plan sponsor to the extent that the requirements of 45 CFR 164.314(b) and 45 CFR 164.504(f) apply and are met;
3. The transmission of ePHI from or to other agencies providing services, disclosed in 45 CFR 164.502(e)(1)(ii)(c), when the covered entity is a health plan that is a government program providing public benefits, if the requirements of 45 CFR 164.502 (e)(1)(ii)(c) are met.

**Procedure:** GIFKwill enter into Business Associate Agreements in compliance with the provisions of HIPAA to establish the permitted and required uses and disclosures of PHI. These provisions can be found in the federal HIPAA regulation 45 CFR 164.504(e).

All Business Associates are required to sign the *GIFK* Business Associate Agreement before services are performed on behalf of GIFK. Access to PHI, account setups, and financial exchanges will not take place until all parties have signed the agreement appropriately. Renewal agreements are monitored for continued compliance with HIPAA regulations by the GIFK Practice Administrator. A list of Business Associate’s contact information will be maintained withGIFK’s HIPAA documentation or the UPA Business Associates Agreement log. This list will include the following information: name, contact information, description of services to be performed, the PHI disclosed to the Business Associate, and dates of any and all contracts in place with the Business Associate, to include initiation and termination dates.

A Business Associate is obligated not to use or further disclose PHI other than as permitted or require by the specific Business Associate Agreement, or as required by law. Appropriate actions will be taken by GIFK with regard to Business Associates when a breach of contractual requirements has been determined. These actions may include termination of services with the Business Associate or vendor and notice of the breach to the Secretary of the Department of Health and Human Services (HHS).

**GIFK**

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| **Policy ID:** COMPL- 12 | **Policy Title:** Documentation Retention | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To establish guidelines with respect to the retention and destruction of GIFK ’s *records.*

**Policy:** All records and documentation created and received by GIFKmust be adequately maintained and protected through the life of the documents. Records no longer needed by GIFKmust be disposed, in accordance with this policy. Records must not be destroyed until the minimum retention guidelines have occurred.

During the life of records and documentation within GIFK, adequate access must be provided to team members to perform all job duties and responsibilities. Reasonable protection and safeguards must be in place at all times to ensure proper security measures are taken to prevent loss, destruction, and theft. All confidential and sensitive documents must be stored in a secured, authorized location or facility.

GIFKmay maintain an agreement with an off-site storage facility to house inactive records for protection and better allocation of space within departments. However, any and all documentation containing PHI must be secured in such a manner that the privacy and security of the records is maintained following regulatory and statutory requirements.

All digital media, whether created or retrieved, must be safeguarded with appropriate security measures and confidentiality to guarantee the protection of sensitive information. Such safeguards may include, network configurations to minimize impact from failed hardware, daily data back-up, and off-site preparedness in the case of disaster.

When records and documents have been identified as inactive or no longer needed, these records may be stored until they can be destroyed. GIFKhas an established a record retention and destruction schedule. Once the retention schedule has been evaluated and items have been moved for destruction, proper protocol must be followed. Destruction of patient health information by GIFKmust be carried out in accordance with Federal and State law. Documentation of this destruction must be maintained permanently within the practice and include the following information: date of destruction; method of destruction; description of the destroyed documents; inclusive dates covered; statement that the records were destroyed in the normal course of business; and signatures of the individuals supervising and witnessing the destruction.   
  
GIFKestablished minimum retention schedule has been attached to this manual as Appendix F. Please refer to this for general questions concerning the retention and destruction of records within the practice. It must be stated that any documentation involved in any open investigation, audit, or litigation must not destroyed until the case has been closed.

**GIFK**

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| **Policy ID:** COMPL- 13 | **Policy Title:** Destruction and Disposal of Sensitive and/or Confidential Information | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To provide a process for the appropriate destruction of documentation and devices containing sensitive and/or confidential information.

**Policy:** Once documents or devices have met their retention timeframes, these items may be destroyed to increase efficiency, reduce costs associated with office/storage space, and to prevent possible PHI disclosure. Following the guidelines laid out in the HIPAA Privacy and Security Rule, GIFKhas created the following safeguarding destruction practices to enhance security and meet the standards for disposal of PHI.

**Procedure:** Paper Documents - Any documentation containing sensitive, protected health information (PHI), to include patient demographic information (name, address, phone, age, sex, SSN, MRN, certificate/license numbers, webpage, etc.), biometric patient information (finger and voice prints), full face photograph, patient financial information, clinical results (when these results uniquely identify a patient), shall be destroyed by shredding, incineration, or discarded in a manner that maintains their confidentiality.

Electronic Records - These records include any sensitive and/or confidential item created, transmitted, or received via electronic media that is property of GIFK. The following methods of destruction may be used depending on the particular medium used for electronic record storage: deleting online data using appropriate utilities; removing or neutralizing the magnetic field/computer tapes to prevent recovery of data through degaussing; removing PHI from mainframe disk drives being sold or replaced using the appropriate initialization utilities; erasing and/or destroying removable media.

Personal Computers / Mobile Devices / Fax Machines – As these devices reach the end of their useful life or computing requirements change, these items may be disposed. However, confidential and PHI information must be removed from these devices in such a manner that the sensitive data cannot be recovered. Any and all GIFK equipment used to create, transmit, and receive sensitive information must be properly wiped clean before reuse and/or removal from GIFKpremises. Also, all information contained on a hard drive must be removed in such a way that meaningful information cannot be recovered from it.

Office Copiers – All copiers used by *GIFK* shall be outfitted with software that combats the improper access and distribution of classified business and/or PHI information. The software’s objective is to remove the information contained and stored in the hard drives of the copiers. Once copiers become obsolete, are scheduled for disposal, or returned to the manufacturer or vendor, steps must be taken to ensure that these drives have been properly cleaned. The *GIFK* may conduct random tests to measure the functionality of this security system.

**GIFK**

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| **Policy ID:** COMPL- 14 | **Policy Title:** Marketing and Fundraising | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To describe the conditions under which PHI may be disclosed for the purposes of marketing and/or fundraising.

**Policy:** There is certain basic information that is permissible to disclose for fundraising purposes without patient authorization, while still maintaining the “Minimum Necessary Standard”. The use of PHI in fundraising includes: demographic information relating to the individual, including name, address, other contact information, age, gender, and date of birth; dates of health care provided to the individual; department of service information, which includes information about the general department of treatment (e.g. oncology, cardiology, etc.); treating physician; outcome information; and health insurance status. It is important to understand that each individual has the opportunity to opt-out of future fundraising communications. All requests should be submitted on the form, Authorization of Use or Disclosure in Marketing and Fundraising, attached as Appendix G.

In the case that GIFK receives financial remuneration for making communications relating to treatment or health care operations on behalf of a third-party entity whose product or service is being marketed, GIFKis required to obtain individual authorization from the patient or patient representative, as applicable. While it is the policy of GIFK to refrain from using or disclosing PHI without written authorization from the patient or patient representative, the HIPAA Privacy Omnibus Rule dictates the below exceptions to this rule.

In reference to marketing,GIFKmust obtain an authorization for use and disclosure except in the following circumstances: (a) if the communication is a face-to-face exchange between GIFKand the individual; (b) if the communication is comprised only of a gift with nominal value given by GIFK. If remuneration is involved in marketing from a third party to GIFK, the authorization must state that remuneration is involved. GIFK shall not sell PHI to any other person or entity.

**GIFK**

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| **Policy ID:** COMPL- 15 | **Policy Title:** Patient Rights | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** The Health Insurance Portability and Accountability Act of 1996 (HIPPA) provides standards and federal requirements for applicable covered entities, business associates, and individuals who create, receive, maintain, or transmit protected health information (PHI). HIPAA also ensures patients of their rights concerning their individual health information. The purpose of this policy is to describe the rights of the patients under HIPAA rules and regulations.

**Policy:** Patients are given certain rights under HIPAA. GIFKis committed to ensuring these rights are honored in every possible case. While each right will be discussed in more detail within this policy, the specific Patients’ Rights are listed as follows:

* The right to receive a notice of privacy practices
* The right to request a specific method of communication
* The right to request restrictions on the use and disclosure of health information
* The right to access protected health information (PHI)
* The right to amend PHI
* The right to an account of disclosures of PHI

Individuals receiving services from GIFKhave the right to an adequate notice of the uses and disclosures of their PHI, as well as notice of their rights and our obligations with respect to their PHI. Providing such notice is an important component of the *GIFK* privacy program. For more information concerning the notice of privacy practices, please refer to policy COMPL-16, Notice of Privacy Practice.

GIFKrecognizes and supports the right of individuals to receive communications regarding their PHI by means and in locations that the individual feels are safe from unauthorized access. Individuals may request communication of PHI by alternative means and alternative locations.GIFKshall make reasonable accommodations to such requests, as required by HIPAA’s Privacy Rule.

Individuals may request certain restrictions on how their PHI is uses and disclosed for treatment, payment, and healthcare operations (TPO), based on HIPAA’s Privacy Rule and Omnibus Rule. Under HIPAA, individuals, also, may request to view and/or receive copies of their protected health information (PHI). GIFKshall make reasonable accommodations to such requests.

GIFKacknowledges and accepts the right of individuals to request amendments to their PHI contained in this organization’s designated record set. This policy does not apply to routine changes, like updates and corrections to demographic, insurance, and financial information. Such changes will be made consistent with normal bookkeeping practices. GIFKvalues and maintains the right of individuals to receive an accounting of certain disclosures of PHI made by covered entities, according to conditions listed in HIPAA’s Privacy Rule.

**Procedure:**

**Privacy Notice**

As stated above, under HIPAA rules and regulations it is a requirement that *GIFK* provide a notice of uses and disclosures of PHI to individuals receiving services. Specifications for the notice of privacy practices can be found in policy COMPL- 16, Notice of Privacy Practices.

**Confidential Methods of Communication**

Confidential communication is a right afforded by HIPAA regulations to patients, regarding their PHI. However, there are certain conditions under which individuals may request to receive communications through alternative means and /or alternate locations. GIFK may require individuals to request confidential communications in writing, either using the appropriate form or in other written methods, an explanation for the request shall not be requested.

GIFKmay contact individuals by telephone, mail, or email to communicate or collect PHI related to treatment, payment, or healthcare operations, including but not limited to appointment reminders, pre-registration and pre- and post-operative information, informing patient of test results, communicating follow-up care instructions, and as necessary for clarification of billing and/or collections purposes. The Minimum Necessary standard applies particularly when PHI is sent in the mail on a postcard, in an envelope with explicit information on the outside of the envelope that may reveal the individual’s medical condition; in a message left with someone other than the patient or on an answering machine or voicemail, and when information is sent via email without encryption or other safeguards in place.

When individuals request an alternate address or method of contact, they must confirm that it is acceptable to use the alternate address for billing purposes, if they are responsible for payment. GIFK may refuse requests for confidential communications that prevent billing and receiving payment.

Some examples of reasonable requests:

* A patient may request that their health information not be given to their health insurer for a particular visit, provided that the patient has paid in full at the time of service and the visit will not be submitted to the insurance carrier. This communications request would apply to a specific visit and would not be ongoing.
* A patient may request to receive mail at a post office box rather than a home address.
* An individual may request to receive telephone calls at the office rather than at home.

**Restrictions on Use and Disclosure**

Patients can request thatGIFKmaintain certain restrictions when concerning the use and disclosure of their PHI for treatment, payment, and healthcare operations (TPO). Nevertheless, particular guidelines must be followed by the patient to ensure their request is properly assessed.

Requests must be submitted in writing on the appropriate form “Request for Restriction on Use or Disclosure of Protected Health Information”, attached as Appendix H. GIFKis not required to agree with most requests for restrictions. However, we are required to agree to a request by an individual to not disclose PHI to a health plan for payment or operations when that PHI pertains solely to a healthcare item or service for which the provider has been paid in full, out of pocket by the patient.

GIFK may grant the request, deny the request, or grant part of and deny part of the request. The decision will be determined on an individual basis, considering our administrative and technical abilities, other relevant laws and regulations, and the overall best medical interests of the patient in our professional judgment. Although decision-making may involve multiple parties, the final decision must be approved by management.

IfGIFKagrees to a restriction, it will be documented in the record and kept on file for at least six (6) years from the date it was last in effect. An agreement to a restriction by GIFKis binding across the organization and for all future uses and disclosures of the patient’s PHI, until the agreement is terminated or under one of the following special circumstances: PHI is needed to provide emergency treatment; PHI is disclosed to the U.S. Department of Health and Human Services in its audit of the organization’s compliance with HIPAA privacy regulations.

GIFK will respond to a request for restriction within thirty (30) days with the following in writing: a statement that the request has been reviewed; a description of the restriction being agreed to or denied; and if denied, the basis on which the denial is made. A patient has the right to respond to a denial and file a complaint.

There are certain instances in which a restriction can be terminated. One of which is when a patient agrees to or requests the termination, in writing. Please see form “Termination of Agreement to Restrict Use or Disclosure of Protected Health Information”, attached as Appendix I. The next instance is when a patient orally agrees to the termination, and the oral agreement to terminate the restriction is documented. The last instance is when GIFKunilaterally terminates the agreement to the restriction by informing the patient in writing. In this case, the termination applies only to PHI created or received after notifying the patient of the termination.

**Access to Protected Health Information**

Patients have a right to access their PHI in their designated record set. The protocol for these requests varies from practice to practice. Please see policy COMPL- 17, Access to Designated Record Set for more details on the appropriate procedure.

**Amending PHI**

Medical records are the property of the organization that created them and are maintained for treatment and continuity of care, reimbursement, legal, research, and other purposes. Therefore, it is vital that all entries be legible, accurate, and complete. When errors in documentation occur, they must be corrected according to the process described in this policy to ensure data integrity.

Medical record information may not be deleted. Upon on inspection of health records, a patient may request an amendment consisting of a change or an addition. The request must be submitted in writing on the appropriate form “Individual’s Request for Amendments to PHI”, attached as Appendix J. This form, then, becomes part of the medical record.

If using a paper medical chart, corrections will be made by drawing a single line through the original entry in such a way that it remains legible. “Error” should be printed at the top of the entry, and persons making such changes should write their initials, title, and date of the change near the correction. If the medical chart is electronic, corrections will be made in the source system by appropriate personnel with support and coordination from IT, when required.

The attending physician(s) will be notified of other requests for correction or amendment of PHI and will decide whether to make the correction or amendment. The patient will be notified, in writing, within sixty (60) days of receipt of his/her written request for amendment of the decision whether to amend the record. If unable to act on the amendment within sixty (60) days, the period may be extended for no more than thirty (30) days as long as the individual is provided with a written statement of the reasons for the delay.

If the request for the amendment is granted, the information will be amended, the patient will be informed of the change, and others who have a “need to know” will be notified of the change. In addition, the hospital or office will make reasonable efforts to notify other relevant persons identified by the patient of the change.

Requests for amendments may be denied for any of the following reasons:

* the information is inaccurate and/or incomplete
* the information is not in the individual’s Designated Record Set
* the information was not generated at this facility
* the originator of the PHI to be amended is no longer available to act on the requested amendment

If the request for amendment is denied, a written statement will be sent to the patient including the following information: the reason for denial, the patient’s right to submit a statement disagreeing with the denial, the patient’s right to ask that the original amendment request and denial be attached to any future disclosures of the information, how to complain to the facility and/or the Secretary of the Department of Health and Human Services about the denial.

Upon determination of the request, the form, “Acceptance of Request for Amendment of Protected Health Information”, will be used to inform the patient of the proceeding actions that will be taken by GIFK on their behalf. Please see this form, attached as Appendix K. The completed amendment request form will be filed in the paper medical record and/or scanned into the electronic medical record.

**Accounting of Disclosures of PHI**

GIFK and its agents will maintain systems to document disclosures of PHI that must be included in an accounting and enable retrieval and reporting of such information on demand. Certain disclosures must be tracked for a minimum of six (6) years from the date of disclosure. These include, but are not limited to the following:

* To public health authorities
  + - for surveillance, investigations, and interventions
    - for recording births/deaths
    - for reporting child abuse or elder abuse
    - for prevention of serious harm
    - for communicable disease reporting
* To the U.S. Food and Drug Administration
  + - for adverse events, product defects, or biological product deviations
    - to track products
    - to enable product recalls, repairs, or replacements
    - to conduct post-marketing surveillance
    - for manufacturers of defective products
* To employers
  + - requesting healthcare be provided to their team members
    - for workplace medical surveillance
    - regarding a work-related injury or illness
    - as required by the U.S. Occupational Safety and Health Administration (OSHA) or similar state law
* To health oversight agencies
  + - government benefit programs
    - compliance
    - civil rights laws
    - trauma registries
    - cancer and/or tumor registries
    - vital statistics
* For judicial and administrative proceedings
  + - court orders
    - subpoenas, unless accompanied by patient authorization
* To law enforcement officials
  + - as required by law
    - to comply with a court order, warrant, subpoena, or summons
    - pursuant to an administrative request
    - to locate a suspect, fugitive, material witness, or missing person
    - as needed for emergency treatment for crime committed elsewhere
    - for victims of crime
    - for crime on premises
    - for suspicious deaths
    - as necessary to avert a serious threat to health or safety
* To coroners or medical examiners
  + - regarding a deceased patient
* To organ/tissue procurement agencies
  + - regarding a deceased patient
* For specialized government functions
  + - military and veterans activities
    - protective services
    - Department of State: medical suitability
    - government programs providing public benefits
    - foreign military personnel
* To workers’ compensation insurers, case managers, etc.
  + - if not for treatment or payment
* For research
  + - if not made with an authorization

The accounting of disclosures will not include any of the following disclosures:

* For treatment, payment, and healthcare operations (TPO)
* To the patient (or personal representative) of the patient’s PHI
* Pursuant to the patient’s authorization
* Certain permitted disclosures, including:
  + - for the facility’s directory
    - to person involved in the patient’s care or for other notification purposes
* For national security or intelligence purposes
* To correctional institutions or in law enforcement custodial situations
* As part of a limited data set under a data use agreement, in accordance with 45 CFR 164.514(e)
* Disclosures that occurred more than six (6) years prior to the date of request

Patients must submit request for an account of disclosure on the appropriate form, “Request for Accounting of Disclosures”, attached as Appendix L. This will be filed in the medical record and kept for at least six (6) years from the date the account is delivered.

The written accounting will be logged using the form “Documentation for the Disclosure of Protected Health Information”, attached as Appendix M. It will contain the following for each disclosure by GIFKor its agents, including business associates:

-The date of the disclosure

-The entity that received the PHI and, if known, the address

-A brief description of the PHI disclosed

-A brief statement of the purpose for the disclosure that reasonably informs the individual of the basis for the disclosure

The accounting must be provided no later than sixty (60) days after the receipt of the request. A one-time, thirty (30) day extension is allowed if the information is stored off-site. If an extension is required, the requesting party will be informed in writing of the reason for the delay and when they will be provided the accounting. A copy of the request form will accompany the disclosures accounting.

No fee will be charged for the first accounting provided to a patient during any twelve (12) month period. A reasonable, cost-based fee may be charged for each subsequent request by the same individual within the twelve (12) month period. Individuals must be informed in advance of any fees required so they have a chance to modify or withdraw their request.

**Time-Limited Exceptions**

Health oversight agencies or law enforcement officials may request to temporarily suspend a patient’s right to an accounting of disclosures for a time period specified by them, provided that:

-The agency or official gives GIFKa written statement stating that providing the patient with an accounting of disclosures to that agency would be likely to impede the activities of the agency or official

-The agency or law enforcement official submits its request on letterhead stationary (or other official communications) of the agency

GIFKmay temporarily agree to suspend a patient’s right to an account of disclosures if a health oversight agency or law enforcement official orally requests it. Oral requests may be acted upon for an initial forty-eight (48) hour period. The GIFKCompliance Director will document the request for suspension, including the date and time of the oral request and the full name, credentials, address, and telephone number of the agency requesting the suspension.

**GIFK**

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| **Policy ID:** COMPL- 16 | **Policy Title:** Notice of Privacy Practices | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To impart guidance to team members in regard to the HIPPA Privacy Rule requirements regardingGIFK’s Privacy Notice.

**Policy:** GIFKshalldevelop and make available a privacy notice that informs patients and the public as to how their Protected Health Information (PHI) is used and disclosed. This notice includes the individual’s rights and obligations with respect to their PHI. A Notice of Privacy Practice template is attached within Appendix N.

**Procedure:**

**Requirements**

The following information is required to be included within GIFKPrivacy Notice:

* This following statement must be included prominently within the document, preferably within the header. “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.”
* Identification of GIFKand to whom these privacy obligations apply
* A description, including at least one example, of the types of uses and disclosures that GIFKis permitted to make for purposes of treatment, payment, and healthcare operations, with sufficient detail to place an individual on notice of the uses and disclosures permitted or required
* A description of each of the other purposes for which GIFKis permitted or required to use or disclose PHI without an individual’s consent or authorization, with sufficient detail to place an individual on notice of the uses and disclosures permitted or required
* A statement that other uses or disclosures will be made only with the individual’s written authorization, and that the authorization may be revoked at any time, in accordance with policy COMPL- 15, Patient’s Rights policy.
* If GIFKintends to contact the individual for appointment reminders, treatment alternatives, or other health-related benefits, a separate statement describing such contacts
* If GIFKintends to contact the individual for fundraising activities, a statement describing such contacts and instructions for opting out
* A statement of the individual’s rights with respect to his or her PHI, and a brief description of how the individual may exercise those rights, including:
  + The right to request restrictions on certain uses/disclosures of PHI, and the fact that GIFKdoes not have to agree to such restrictions except in the following instance:
* The right to request restriction on disclosure for payment and healthcare operations when the individual (or representative) pays in full, out of pocket
  + The right to receive confidential communications of PHI
  + The right to inspect and copy PHI
  + The right to request amendment of PHI
  + The right to receive an accounting of certain disclosures of PHI
  + The right to receive a paper copy of the Privacy Notice
* A statement ofGIFK ’s duties with respect to PHI, including statements: that GIFKwill notify individuals if their information is breached; that GIFK is required by law to maintain the privacy of PHI and to provide individuals with Notice of its legal duties and privacy policies; that GIFKis required to abide by the terms of the currently effective Privacy Notice; and that GIFKreserves the right to change the terms of the Notice and make the new Notice provisions effective for all PHI maintained, along with a description of how we will provide individuals with the revised Notice
* A statement that individuals may complain to GIFKand to the Secretary of the U.S. Department of Health and Human Services about privacy rights violations, including a brief statement about how a complaint may be filed and an assurance that the individual will not be retaliated against for filing a complaint
* The name or title and telephone number of the person or office to contact for further information
* The effective date of the Notice, which may not be earlier than the date printed or published

**Revisions to Privacy Notice**

GIFKwill promptly revise and distribute the Privacy Notice whenever there is a material change to the uses or disclosures, the individual’s rights, our legal duties, or other privacy practices described in the Notice. Except when required by law, a material change to any term may not be implemented prior to the effective date of the Notice reflecting the change.

**Document Retention**

GIFKwill retain a copy of each version of our Privacy Notice issued for a period of at least six (6) years from the Notice’s last effective date. GIFK will also retain documentation of an individual’s acknowledgement of receipt or documented attempts to obtain such acknowledgements of the Privacy Notice for a period of no less than six (6) years from the date of the Acknowledgement of Receipt document.

**Provision of Privacy Notice**

To individual patients

* Each new patient will be given a copy of the Privacy Notice on his or her first visit for care or services.
* Patients will be asked to sign an Acknowledgement of Receipt of our Privacy Notice. Patients may refuse or be unable to sign, in which case staff will document the attempt on the Acknowledgement of Receipt for Notice of Privacy Practices form, attached as Appendix N.
* If a patient’s first service is by telephone (e.g., a prescription refill or phone consultation) and an office visit is not imminent, then staff will mail the Privacy Notice and Acknowledgement of Receipt form to the patient with instructions and a request to return the signed form. This action will be documented in the patient’s record and qualifies as a good-faith effort should be documented in the record.
* Acknowledgement forms are filed in the patient’s medical record.
* If and whenGIFK ’s Privacy Notice is revised, we will post it and make copies available. We are not required to hand out copies of the revised Notice to patients who have received an earlier version, nor are we request to obtain a new Acknowledgement of Receipt from such patients.

To our patient population and the public

* The current version of the Privacy Notice will be posted prominently in (the GIFK facilities and on the website
* Copies of the Privacy Notice will be readily available at all service locations and to anyone who requests one

**GIFK**

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| **Policy ID:** COMPL- 17 | **Policy Title:** Access to Designated Record Set | **Prepared by:** |
| **Effective Date:** 01/20/2015 | **Reviewed Date:** | **Amended:** |

**Objective:** To explainGIFKpolicy for providing patient’s the right to their designated records set.

**Policy:** GIFKas a covered entity is committed to enabling its patients to exercise their legal rights in accessing and amending their protected health information (PHI) contained in their designated record set (DRS).

An individual’s right to access generally applies to the information that exists within a covered entity’s DRS(s), including: (1) a healthcare provider’s medical and billing records, (2) a health plan’s enrollment, payment, claims adjudication, and care or medical management record systems, and (3) any information used, in whole or in part, by or for the covered entity to make decisions about individuals. This includes all records used to provide medical care by a specific doctor, whether specific doctor created or received from another medical source. I thought that we could not release records from referring MD???

According to HIPAA Privacy Rule, GIFKshall provide access to the PHI in the form or format requested by the individual, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format requested, access must be provided in a readable hard copy form, or in an alternative format, as agreed to by *GIFK* and the individual. GIFKmay provide the individual with a summary of the PHI or may provide an explanation of the PHI, which has been provided, so long as the individual agrees to the alternative form and associated fees, if applicable.

According to HIPAA Privacy Rule, patients have the right to access their personal health records and are entitled to receive copies or summaries of such records. The only exceptions to this include, minors, some mental health records, and some records related to the treatment for alcohol and drug abuse.

All business associates, who maintain or otherwise operate electronic records forGIFK,are obligated to share no duplicative information pursuant to electronic access requests. The same would be true if a health information organization, as a business associate, maintains an electronic storehouse of some or allGIFK’s PHI. If there are any further questions, refer back to policy COMPL-11, Business Associate Agreement.

All records requests should be made in writing using the appropriate form, Authorization for Use or Disclosure of Protected Health Information, attached as Appendix A.GIFK’steam members must follow the appropriate policy for the verification of identity for any person who requests PHI, as well as their authority to have access to such information, if the identity or authority of the person is not already known. These verification requirements apply to individuals who request access to their PHI that is maintained in a designated record set.

When an individual other than the patient, such as a personal representative, requests access to PHI, that person must be legally authorized to act on behalf of an individual regarding health matters. Generally, they will be granted the same access as the patient. State law will be used to determine when a person has the legal authority to act on behalf of an individual with regard to healthcare matters. Health care power of attorney and parental rights, for example, are two legal bases by which state law may be determinative of a person’s authority to act on behalf of an individual.

Verification may be obtained either orally, or in writing (which may be satisfied electronically), so long as the requisite documentation, statements, or representations are obtained where required by a specific Privacy Rule disclosure provision, and that the appropriate steps are ultimately taken to verify the identity and authority of individuals or personal representatives who are otherwise unknown.

The Privacy Rule establishes circumstances under which GIFKmay deny an individual access to PHI and distinguishes those grounds for denial, which are reviewable from those that are not. The following are unreviewable grounds for request denials: situations involving (a) psychotherapy notes, information complied for use in legal proceedings, and certain information held by clinical laboratories, such as HIV; (b) certain requests which are made by inmates of correctional institutions; (c) information created or obtained during research that includes treatment if certain conditions are met; (d) denials permitted by the Privacy Act; (e) information obtained from non-healthcare providers pursuant to promises of confidentiality. The following are reviewable grounds for request denials: (a) disclosures which would cause endangerment of the individual or another person; (b) situations where the PHI refers to another and disclosure is likely to cause substantial harm; and (c) requests made by a personal representative where disclosure is likely to cause substantial harm.

All denials will be provided in a timely manner, written form. It will be written in plain language with a description of the basis of denial and statements of the individual’s rights to have the decision reviewed, if applicable, and how to request such a review. This notice will serve the individual with how complaints may be filed with GIFK or the Secretary of HHS. GIFKmay satisfy this requirement for denials via paper or electronic form. Patients will be notified of all determinations concerning their request for record access within thirty (30) days upon receipt of the request. All patients may be required to pay for the cost of copying and mailing requested documentation.

**Appendix A**

**GIFK**

**Authorization for Use or Disclosure of Protected Health Information (PHI)**

All sections must be completed, signed, and dated for this form to be valid.

**Patient Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my health record.**

**This information may be disclosed by:**

Practice Name/Name of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**And, is to be provided to:**

Name of Person/Practice/Organization/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information to be disclosed from my health record:** (Please check all that apply.)

\_\_ Entire record

\_\_ Only information related to (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Only the period of events from (specify dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Other (specify) (Billing, Labs, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I would like the following sensitive information disclosed:** (Please check the applicable items, below.)

\_\_ Alcohol/Drug Abuse Treatment/Referral \_\_ HIV/AIDS- related Treatment

\_\_ Sexually Transmitted Diseases \_\_ Mental Health *(Other than Psychotherapy notes)*

\_\_ Psychotherapy Notes ONLY *(Please note that by checking this box you are waiving any psychotherapist-patient privilege.*

**The purpose or need of this disclosure is:**

**\_\_** Further Medical Care \_\_ Attorney \_\_ School \_\_ Research

\_\_ Personal Use \_\_ Insurance \_\_ Disability

\_\_ Other *(Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a difference expiration date or expiration event is stated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Specify new date)*

I understand that GIFK will not condition treatment or eligibility of care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to disclosure by the recipient and may no longer be protected by the Health Insurance Portability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative *(State relationship to patient)* Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness *(If signature of patient is a thumbprint or mark)* Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

**Instructions for Completing**

**“GIFKAuthorization for Use or Disclosure of Protected Health Information” Form**

1. Print legibly in all fields using a dark permanent ink.
2. Patient must print their name or the name of the patient whose information is to be released.
3. Print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.
4. State the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc.
5. Check the appropriate box as applicable.
   1. “Only information related to” – specify diagnosis, injury, operations, special therapies, etc.
   2. “Only the period of events from” – specify date range, e.g., Jan. 1, 2002 to Feb. 1, 2002.
   3. “Other (Specify)” – e.g. Billing, Employee Health, Labs
   4. “Entire Record” – complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
   5. **In order to release sensitive information regarding those items listed in the above parenthetical notation, the appropriate box or boxes MUST be checked by the patient.**
   6. **PSYCHOTHERAPY NOTES ONLY – In order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may not be made in conjunction with authorizations pertaining to psychotherapy notes.**

**If this box is checked with other boxes, another authorization will be required to authorize the use or disclosure of psychotherapy notes.**

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist’s impression about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

1. If a different expiration date is desired specify a new date.
2. Please sign (or mark) and date.
3. A copy of this completed form will be given to the patient or patient representative.

**Appendix B**

**GIFK**

**Individual Revocation of Authorization to Use or the Disclosure of Protected Health Information**

This form is to be used when revoking a request for access and disclosure of protected health information.

I**, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** hereby revoke an authorization dated \_\_\_\_\_\_\_\_\_\_ [use approximate date, if date of authorization is unknown] to use or disclose individually identifiable health information about me except to the extent that action has been taken in reliance on that authorization. If the authorization was obtained as a condition of my obtaining insurance coverage, I understand that this revocation is effective only to the extent that other law provides the insurer with the right to contest a claim under the policy.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient *(if applicable)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix C**

**GIFK**

**[Insert Practice’s Name]**

**New Team Member Orientation Training Checklist**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | |  | |  | |  |  | | |  | **Date:** |  | |  | | |  |
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|  | |  | |  | |  |  | | |  |  |  | | **Team Member's Initials** | | | **Trainer's Initials** |
| **Executive Director Introduction** | | | | | |  |  | | |  |  |  | |  | | |  |
|  | | Org Chart | |  | |  |  | | |  |  |  | |  | | |  |
|  | | UPA Website | | | |  |  | | |  |  |  | |  | | |  |
|  | |  | |  | |  |  | | |  |  |  | |  | | |  |
| **Human Resources** | | | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Personal Data Form | | | |  |  | | |  |  |  | |  | | |  |
|  | | W-4 | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Direct Deposit Authorization | | | | |  | | |  |  |  | |  | | |  |
|  | | I-9 Verification | | | |  |  | | |  |  |  | |  | | |  |
|  | | Cell Phone Discount | | | |  |  | | |  |  |  | |  | | |  |
|  | | AAA Discount | | | |  |  | | |  |  |  | |  | | |  |
|  | | Payroll Schedule | | | |  |  | | |  |  |  | |  | | |  |
|  | | Paylocity Website | | | |  |  | | |  |  |  | |  | | |  |
|  | |  | |  | |  |  | | |  |  |  | |  | | |  |
| **Safety Program** | | | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Safety program Overview | | | |  |  | | |  |  |  | |  | | |  |
|  | | Safety Agreement | | | |  |  | | |  |  |  | |  | | |  |
|  | | Fire and Safety | | | |  |  | | |  |  |  | |  | | |  |
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| **Halogen eLearning** | | | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Halogen Activation Process | | | | |  | | |  |  |  | |  | | |  |
|  | | Stroke Module | | | |  |  | | |  |  |  | |  | | |  |
|  | |  | |  | |  |  | | |  |  |  | |  | | |  |
| **Handbook Overview** | | | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Wage & Hour Policies | | | |  |  | | |  |  |  | |  | | |  |
|  | | Leaves | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Initial Evaluation Period | | | |  |  | | |  |  |  | |  | | |  |
|  | | Performance Reviews | | | |  |  | | |  |  |  | |  | | |  |
|  | | Attendance | | | |  |  | | |  |  |  | |  | | |  |
|  | | Dress Code | | | |  |  | | |  |  |  | |  | | |  |
|  | | Smoking/Substance Abuse | | | | |  | | |  |  |  | |  | | |  |
|  | | Resignation | | | |  |  | | |  |  |  | |  | | |  |
|  | | Exit interviews | | | |  |  | | |  |  |  | |  | | |  |
|  | | Confidential Information/HIPAA | | | | |  | | |  |  |  | |  | | |  |
|  | | Equal Employment Opportunity | | | | |  | | |  |  |  | |  | | |  |
|  | | Harassment Policy | | | |  |  | | |  |  |  | |  | | |  |
|  | | Standards of Conduct | | | |  |  | | |  |  |  | |  | | |  |
|  | |  | |  | |  |  | | |  |  |  | | **Team Member's Initials** | | | **Trainer's Initials** |
|  | | Personal/ phone/ computer/ and email | | | | | | | |  |  |  | |  | | |  |
|  | | Workplace violence | | | |  |  | | |  |  |  | |  | | |  |
|  | | Licensure | | | |  |  | | |  |  |  | |  | | |  |
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| **Regulations and Compliance** | | | | | |  |  | | |  |  |  | |  | | |  |
|  | | Fraud Waste and Abuse | | | |  |  | | |  |  |  | |  | | |  |
|  | | Business Conduct & Integrity | | | | |  | | |  |  |  | |  | | |  |
|  | | Bloodborne Pathogens | | | |  |  | | |  |  |  | |  | | |  |
|  | | HAZCOM | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Red Flag | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Infection Control | | | |  |  | | |  |  |  | |  | | |  |
|  | | Compliance/Hotline | | | |  |  | | |  |  |  | |  | | |  |
|  | | Retaliation Policy | | | |  |  | | |  |  |  | |  | | |  |
|  | |  | |  | |  |  | | |  |  |  | |  | | |  |
| **Benefits** | |  | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Paylocity enrollment instructions | | | | |  | | |  |  |  | |  | | |  |
|  | | Benefit Summary Sheet | | | |  |  | | |  |  |  | |  | | |  |
|  | | BCBS | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Delta Dental | | | |  |  | | |  |  |  | |  | | |  |
|  | | Vision/Comp Benefits | | | |  |  | | |  |  |  | |  | | |  |
|  | | Colonial | |  | |  |  | | |  |  |  | |  | | |  |
|  | | The Hartford | | | |  |  | | |  |  |  | |  | | |  |
|  | | Basic Life Insurance Beneficiary Form | | | | | | | |  |  |  | |  | | |  |
|  | | TASC | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Transamerica | | | |  |  | | |  |  |  | |  | | |  |
|  | | Plan coverage/Medicare | | | |  |  | | |  |  |  | |  | | |  |
|  | | PTO and Sick Accruals | | | |  |  | | |  |  |  | |  | | |  |
|  | | EAP | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Jury Duty | |  | |  |  | | |  |  |  | |  | | |  |
|  | | Military Leave | | | |  |  | | |  |  |  | |  | | |  |
|  | | Bereavement | | | |  |  | | |  |  |  | |  | | |  |
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| **Team Member Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |  |
|  | |  | |  | | |  |  | |  | |  | |  |  | |  |
| **Trainer Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |  |
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**Appendix D**

**GIFK**

**HIPAA Complaint Form**

This form is to be used when reporting any violation of HIPAA regulations, to include unauthorized use and/or disclosure of protected health information.

Name of person reporting violation: *(Optional)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position held by person reporting violation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of incident being reported: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the potential violation in as much detail as possible, including name(s) of individuals involved and date(s) of relevant incidents, if known. *(Further explanation and documentation maybe attached to this form at the time of submission, if necessary.)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly explain how and when you became aware of this specific violation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please advise the Compliance department of all evidence that would prove the existence of the reported violation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all individuals who might be able to confirm any other related incidents of this specific violation, whether within or outside of GIFK.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you brought this incident to the attention of anyone else within or outside of GIFK ?

\_\_ **Yes**  \_\_ **No**

***If “Yes”, please list the identity and affiliation of the individual(s).***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you be willing to discuss this reported violation with GIFK’s Compliance department?

\_\_ **Yes \_\_ No**

**Please use the following contact information to file your complaint.**

GI For Kids, PLLC

Betzaida Shands

Director of Compliance

9000 Executive Park Drive, C200

Knoxville, TN 37923

[bshands@utmck.edu](mailto:bshands@utmck.edu)

Fax: (865) 670-6098

Compliance Hotline: (865) 305-9283

*By filling out this form, you understand that GIFK , as a covered entity under HIPAA regulations, will not take any retaliatory action against any person, their family members, or acquaintances for lodging a complaint.*

*Confidentiality is strictly observed, except where a reported violation is determined to require further action by a higher authority that GIFK .*

**Appendix E**

**[PLEASE refer to the UPA compliance department for all inquires concerning the UPA business Associate Agreement.]**

**Appendix F**

**Appendix F**

*GIFK* has established a minimum record retention and destruction schedule to provide guidance to management as to when such documents can be destroyed. These policies reflect the requirements to provide the protection of records and documents under the Tennessee statutes of limitations, which govern the time frame after which rights cannot be enforced by civil action in the courts.

The minimum retention and destruction schedule is as follows:

**Medical Practices**

**Record Retention Period**

Patient Records 10 years

Pediatric Patient Records 10 years from last

professional contact with

patient or 1 year after the

minor reaches the age of

majority (i.e. until the

patient turns 19),

whichever is longer

Request for Restriction of Uses and Disclosure 6 years from date last in

of Protected Health Information effect

Authorization for Use or Disclosure of

Protected Health Information

Individual Revocation of Authorization to

Use or Disclose Protected Health Information

HIPAA Complaint form

Business Associate Agreement

Authorization for the Use or Disclosure of

Protected Health Information for Fundraising

and Marketing Purposes

Request for Restriction on the Use or Disclosure

of Protected Health Information

Termination of Agreement to Restrict Use or

Disclosure of Protected Health Information

Individual’s Request for Amendment to

Protected Health Information

Acceptance of Request for Amendment to

Protected Health Information

Request for Accounting of Protected Health

Information Disclosures

Disclosure of Protected Health Information

Acknowledgement of Receipt of Notice

of Privacy Practices

Teammate Training Documentation

Fraud, Waste, and Abuse Training Documentation

Appendix G

**Authorization for the Use and Disclosure of PHI for Fundraising and Marketing Purposes**

**Appendix H**

**GIFK**

**Request for Restriction on the Use or Disclosure of Protected Health Information**

This form should be used when a patient requests restrictions to the use and disclosure of their protected health information.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Restrictions**

*(If appropriate, please place a check in the blank provided. Ensure that all information is written clearly and completely.)*

I request the following restriction(s) on the use or disclosure of my protected health information:

\_\_\_ Do not release information to the following person(s):

*(If checked, please specify said person(s), below.)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the information you would like limited, below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***GIFK* may use or disclose the patient’s health information for the purposes of treatment, payment, and healthcare operations. Patients have the right to request a restriction related to the use and disclosure of their personal health information, but this organization is not always required to agree to the request.**

***GIFK* is required to agree to your request in the following situation:**

If the patient or their representative pay in full and out of pocket for a healthcare service or product ***GIFK*** provided, and they request that we do not disclose that information to their health plan, please check here \_\_\_.

**If *GIFK* agrees to the restriction, the patient’s information may still be shared in the following circumstances:**

* During medical emergency, if the restricted information is needed to provide emergency treatment for the patient. However, if the information is disclosed during an emergency, ***GIFK*** will inform the recipient not to use or disclose it for any other purposes.
* For certain public health activities.
* For reporting abuse, neglect, violence, or other crimes.
* For health agency oversight activities or law enforcement investigations.
* For judicial or administrative proceedings.
* For identifying decedents to coroners and medical examiners or determining a cause of death.
* For certain research activities.
* For Workers’ Compensation programs.
* For uses or disclosures required by law.

**If the restriction is agreed to by *GI For Kids, PLLC*, it may be terminated if:**

1. The patient or patient representative requests termination of the restriction in writing through the form “Termination of Agreement to Restrict Use or Disclosure of Protected Health Information”.
2. The patient or patient representative orally request or agree to termination of the restriction.
3. *GIFK* informs the patient or patient representative in writing that this organization is terminating the restriction. In this case, the restriction will continue to apply to the information already possessed, but it will not apply to the health information created or received after the patient has been notified of the termination.

Signature of Patient or Patient Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If representative, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Internal Use Only**

Date request received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request for restriction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Approved \_\_\_ Denied

Compliance Officer signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date patient was notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix I**

**GIFK**

**Termination of Agreement to Restrict the Use or Disclosure of Protected Health Information**

This form is to be used when someone wishes to end a restrictive PHI agreement previously made.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The agreement of *GIFK* to observe the request of

*(name of patient)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to restrict the use or disclosure of his/her protected health information is hereby terminated as evidenced below: *(Check all applicable)*

\_\_ The individual has agreed to termination by signing below.

\_\_ The individual orally agreed to termination on:

*(Date)* \_\_\_\_\_\_\_\_\_\_\_ at *(location/by phone)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Conveyed to *(Person’s name)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ The individual has agreed that termination applies to all protected health information to which the restriction was applicable.

\_\_ The individual has agreed to termination only to the following extent or for the following purposes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ The individual has been told that agreement is terminated, but only with regard to protected health information created or received after informing the individual of termination.

Individual’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By *(Signature):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_ Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix J**

**GIFK**

**Individual’s Request for Amendment to Protected Health Information**

This form is to be used when a patient wishes to amend their personal protected health information.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby request that my protected health information be amended as follows: *(Additional pages may be attached, if needed)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am requesting this amendment because: *(Additional pages may be attached, if needed.)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix K**

**GIFK**

**Acceptance of Request for Amendment of Protected Health Information**

This form is to be used when documenting a final decision concerning a protected health information amendment request.

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your request, dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to amend your protected health information has:

\_\_ Been granted in its entirety.

\_\_ Been granted partially as to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The remainder of your request has been denied. See attached form regarding the portion denied.

Please inform us of any persons or entities who have received your protected health information to which we should provide the amendment, along with giving us your authorization to disclose the information. The name of the practice/facility, treating physician, address of practice, and contact number for the practice must be included on the lines provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Send this information to: *(insert Practice’s name and contact information to include: name, address, city, state, zip code)*

**For Office Use Only**

**-----------**

***GIFK***

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Form Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix L**

**GIFK**

**Request for Accounting of Disclosures**

Please fill out this form in its entirety.

*Please note that you have the right to request an accounting of disclosures concerning your protected health information (PHI). However, we may charge a reasonable fee for the costs of providing this list to you. We will notify you of the cost involved before any costs are incurred. This will allow you to assess your request and modify and/or withdraw, if you so choose.*

**Patient’s Name:** (Please print.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I request an accounting of disclosures of my health records for the following time period:**

(Please provide a starting and ending date for proper processing.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By filling out and signing this request, you understand that this accounting:

* Will not include disclosures from more than six (6) years ago
* Will not include disclosures for the treatment, payment, or healthcare operations of practice
* Will not include disclosures to me or for which you (or your personal representative) signed an authorization
* Will not include disclosures, if any, from a hospital directory if you were in the hospital and did not restrict sharing that information
* Will not include disclosures incidental to permitted uses and disclosures; will not include disclosures made as part of a limited data set when it is reasonably unlikely that the information could identify you; and will not include certain other disclosures protected by law, such as for national security, to correctional institutions, or for health oversight or law enforcement officials when the agency required the practice to temporarily suspend patient access to the accounting.

I understand that the practice will respond within sixty (60) days of receipt of this request.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If a personal representative, print name and relationship to patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Practice’s Use Only

***Completed and mailed with attached Accounting of Disclosures log:***

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix M**

**GIFK**

**Disclosure of Protected Health Information**

This form is to be used when disclosing any protected health information, and serves as documentation for this type of disclosure.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of information disclosed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the disclosure of PHI is required for any for the below authorities, please see the back page of this form for further explanation required for this release, concerning entity documentation.

Authority for Disclosure: *(Check all that apply.)*

\_\_ Individual authorization *(attach form)*  \_\_ Workers’ Compensation

\_\_ Government Program *(Government entities only)* \_\_ Judicial of Administrative Processing

\_\_ To Coroner or Medical Examiner \_\_ Avert Threat to Health or Safety

\_\_ Organ, Eye, or Tissue Donation

\_\_ Required by law\* \_\_ Research Purposes\*

\_\_ Authorized Public Health Activities\* \_\_ Report of Abuse\*

\_\_ Health Oversight Agency Activity\* \_\_ Law Enforcement Purposes\*

\_\_ Specialized Government Function\*

**Disclosure of Protected Health Information:**

**Documentation or Information Authorizing Disclosure**

\*This portion of the form should only be used if any entity in the lower portion of the previous form is requiring the release of protected health information. This serves as accurate documentation of PHI disclosure and must be forwarded to the \_\_\_\_\_ department for the Disclosure Log file.

Place a check in the applicable blank and complete the specific requirements attached to specific blanks.

**\_\_ Individual authorization: \_\_ Required by law:**

*Attach completed, signed, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*and dated Authorization form Identify Legal Authority*

\_\_ **Authorized Public Health Activities: \_\_ Report of Abuse:**

*Identify the public health activity Identify any law requiring report*

*pursuant to which the disclosure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*is made. Attach Patient’s authorization,*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* or

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* \_\_ *Decision was made without patient*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorization and notice of disclosure*

*was given to patient.*

\_\_ **Health Oversight Agency Activity:**

*Identify agency and activity* **\_\_ Judicial or Administrative Proceeding:**

*involved. Attach order, if disclosure is required.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Otherwise, attach “Satisfactory*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assurances” of requester and copy of*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ letter giving notice.*

**\_\_ Law Enforcement Purposes:**\_\_ **Research Purposes:**

*Identify law requiring**Reference IRB or Privacy Board Waiver*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Or

*Attach order or legal process* \_\_ **Avert Threat to Health or Safety:**

*Requiring, or check permissible Explain threat.*

*Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_*Locating suspect, witness, etc \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Information about crime victim \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\_\_*Decedent is suspected of crime victim

\_\_Suspected crime activity here \_\_ **Specialized Government Function:**

\_\_ Suspected crime at emergency site *Identify function:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Disclosure Approved By: *(Signature)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approval Date: \_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix N**

|  |  |  |
| --- | --- | --- |
| |  |  | | --- | --- | |  |  |   *Effective Date*: *\_\_\_\_\_\_\_\_\_\_*  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.  If you have any questions about this notice, please contact \_\_\_\_\_\_\_.  **OUR OBLIGATIONS:**  We are required by law to:   * Maintain the privacy of protected health information * Give you this notice of our legal duties and privacy practices regarding health information about you * Follow the terms of our notice that is currently in effect   **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:**  The following describes the ways we may use and disclose health information that identifies you (“Health Information”). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.  ***For Treatment***. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.  ***For Payment***. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.  ***For Health Care Operations***. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.  ***Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services***. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.  ***Individuals Involved in Your Care or Payment for Your Care***. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.  ***Research***. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.  **SPECIAL SITUATIONS:**  ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.  ***To Avert a Serious Threat to Health or Safety***. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.  ***Business Associates***. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.  ***Organ and Tissue Donation***. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.  ***Military and Veterans***. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.  ***Workers’ Compensation***. We may release Health Information for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.  ***Public Health Risks***. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.  ***Health Oversight Activities***. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.  ***Data Breach Notification Purposes.*** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.  ***Lawsuits and Disputes***. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.  ***Law Enforcement***. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person’s agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.  ***Coroners, Medical Examiners and Funeral Directors***. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.  ***National Security and Intelligence Activities***. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.  ***Protective Services for the President and Others***. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.  ***Inmates or Individuals in Custody***. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.  **USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT**  ***Individuals Involved in Your Care or Payment for Your Care.*** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person’s involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.  ***Disaster Relief.*** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.  **YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**  The following uses and disclosures of your Protected Health Information will be made only with your written authorization:   1. Uses and disclosures of Protected Health Information for marketing purposes; and 2. Disclosures that constitute a sale of your Protected Health Information   Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.  **YOUR RIGHTS**:  You have the following rights regarding Health Information we have about you:  ***Right to Inspect and Copy***. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to \_\_\_\_\_\_\_\_. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.  ***Right to an Electronic Copy of Electronic Medical Records.*** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.  ***Right to Get Notice of a Breach.*** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.  ***Right to Amend***. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to \_\_\_\_\_\_\_\_.  ***Right to an Accounting of Disclosures***. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to \_\_\_\_\_\_\_.  ***Right to Request Restrictions***. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to \_\_\_\_\_\_\_\_. We are not required to agree to your requestunless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.  ***Out-of-Pocket-Payments.*** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.  ***Right to Request Confidential Communications***. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to \_\_\_\_\_\_. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.  ***Right to a Paper Copy of This Notice***. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.\_\_\_\_\_. To obtain a paper copy of this notice, \_\_\_\_\_\_\_\_\_\_.  **CHANGES TO THIS NOTICE:**  We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.  **COMPLAINTS:**  If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact \_\_\_\_\_\_\_\_\_. All complaints must be made in writing. **You will not be penalized for filing a complaint**.  You may contact our office at:  [name of organization]  [address and phone number of organization]  The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for your entire PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.  Revised 01/2013 |

**GIFK**

**Acknowledgement of Receipt for Notice of Privacy Practices**

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Please sign, date, and provide the required information to allow for appropriate filing.

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It is required to record the fact that you received a copy of our Privacy Notice.

I, *(Printed patient’s/representative’s Name)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of *GI For Kids, PLLC’s* Notice of Privacy Practices.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Office Use Only**

Written acknowledgement could not be obtained for the following reasons: *(Check all that apply)*

\_\_ Individual refused to sign

\_\_ Communication barriers prohibited obtaining the acknowledgement

\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_ Other *(Please specify.)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*