



HIPAA Privacy Policies

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Table of Contents

HIPAA Privacy Policies	Pages 2-31
Appendices	Pages 32-64
Accounting of Disclosures of Protected Health Information	Page 32
Authorization for Disclosure of Protected Health Information	Page 33
Business Associate Agreement	Pages 34-41
Notice of Privacy Practices	Pages 42-48
Acknowledgement of Receipt of Privacy Practices	Page 49
Request for Accounting of Disclosures of Health Information	Pages 50
Investigation of Potential Privacy Breach	Pages 51-52
Request for Amendment of Protected Health Information	Pages 53-54
HIPAA Staff Member Policy Statement	Page 55
Employee Confidentiality Agreement	Page 56
Consent to Care	Pages 57
Acknowledgement of Receipt of Privacy Practices and Consent to Care Combined	Pages 58-59
Client Request for Confidential Communication	Page 60
Annie Policy	Page 61
Confidentiality Agreement for Outside Agency	Page 62
Academic and Confidentiality Agreement	Pages 63-64



HIPAA PRIVACY POLICIES

Section 1.1 INTRODUCTION

- A. The Stark County General Combined Health District hereinafter referred to as the Stark County Health Department (SCHD) will fully comply with all privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-91, as well as all-applicable state and federal regulations. In addition, these policies will protect health information as required by the provisions of the Health Information Technology for Economic and Clinical Health Act (HITECH), Title VIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment act 2009 (ARRA) (Pub. L. 111-5).
- B. The Stark County Health Department qualifies as a “hybrid entity”. As a hybrid entity, the department is responsible for ensuring HIPAA compliance and oversight to covered health care components within the department.
 - 1. Some entities unquestionably have divisions, which are covered entities, and other divisions, which are uncovered entities under HIPAA. These entities are specifically entitled hybrid entities under HIPAA. If a covered entity is a hybrid entity, the requirements of HIPAA apply only to the covered health care components of the entity. Conversely, any communications between the covered and non-covered portions of the hybrid entity must comply with the privacy and security guidelines.
- C. For the purposes of the SCHD policies, the following elements are considered individual identifiers if they are associated with medical information. Such information will be considered Protected Health Information (PHI) and must be protected from improper use or disclosure.
 - 1. Names
 - 2. All geographic subdivisions smaller than a State (with the exception of a local health department for infectious disease reporting), including street address, city, county, precinct, and zip code.
 - 3. Dates of service



4. Telephone numbers
5. Electronic mail addresses
6. Social Security Numbers
7. Medical Record Numbers
8. Health plan beneficiary numbers
9. Any other unique identifying number, characteristic, or code that can be re-identified.

Section 1.2 PRIVACY OFFICER

- A. Responsibility for compliance with the SCHD privacy policies, including HIPAA regulations and other state and federal rules, is assigned to the Director of Nursing Services. This responsibility includes the management and supervision of:
 1. The use of security measures to protect PHI.
 2. The conduct of personnel in relation to the protection of PHI.
 3. Supervision of all personnel in relation to the protection of PHI.
 4. Assurance that all employees receive initial and annual training, education on the agency's privacy policies and procedures, and have training documented.
 5. Evaluate adherence to policies and procedures to ensure effective implementation.
 6. Audit current policies and procedures to evaluate their adequacy and effectiveness.
- B. The Director of Nursing Services is designated as the contact person who is responsible for receiving and processing complaints under this section. The contact person will be able to provide further information about our privacy policies.
- C. General Questions. In the event any employee has questions concerning disclosure or use of PHI, all such questions will be directed to the Director of Nursing Services.



Section 1.3 CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

- A. All health department PHI, including hard copy and computerized data, concerning an applicant, recipient or former recipient of care are considered as confidential information and will be safeguarded to protect the client from exploitation, harassment and/or embarrassment. No employee of the agency may disclose such information, directly or indirectly, without the client's written authorization, except as required by law, or permitted under the privacy practices of the Stark County Health Department.
- B. Additionally, this policy covers students, volunteers, trainees, contractors, personnel working through a temporary agency, and other persons whose conduct in the performance of work for our department is under the direct control of the department, whether or not they are paid by the department.
- C. All PHI will be maintained in secured areas. Only authorized provider access to the information will be allowed.
- D. Employees shall read and use PHI only as necessary for their job functions. Discussions concerning client's care for the purpose of relaying information shall be discrete and private. Employees will exercise caution when discussing client-sensitive information in an unsecured area.
- E. All records, forms, papers, log sheets, etc. with client names on them will be shredded when being disposed according to the approved SCHD records retention schedule.
- F. PHI maintained in electronic files will be password protected. Computer systems will be in secure locations, have an auto-log-off activation and have anti-virus software installed. All computer systems and data storage units will have a backup for disaster data retrieval. Access to on-line viewing will be controlled through individual, authorized UserIDs. Anyone allowing someone else to use his/her access or to otherwise inappropriately access information on the computer may be subject to disciplinary action.
- G. Passwords will not be stored in readable form without access control or in other locations where unauthorized persons might discover them.



- H. After separation of any employee, all user IDs for that employee will be deleted or inactivated. It is the responsibility of the Unit Manager(s) and or Director of the service area to ensure this action is completed.
- I. It is the responsibility of Stark County Health Department employees to preserve and protect the confidentiality and privacy of health department clients by adhering to department policy, as well as State and Federal laws and regulations.
- J. Repeating or in any way disseminating PHI, except as permitted or required by law, is considered unauthorized disclosure of medical information and is a serious offense which may have personal civil and/or criminal liability. In accordance with the health department's personnel policy, violation of this policy may be grounds for disciplinary action.
- K. All employees shall be informed of the mandatory nature of confidentiality and be required to sign an employee confidentiality agreement at the time of hire and then annually.

Section 1.4 NOTICE OF PRIVACY PRACTICES

- A. Stark County Health Department will provide a Notice of Privacy Practices (See Sample Notice of Privacy Practices in Appendix) to individuals applying for or receiving covered health care services. Additionally, the department shall make its Notice of Privacy Practices available to any individual(s) upon request, whether or not the individual is an agency client.
- B. The Notice of Privacy Practices will outline the uses and disclosures of protected health information that may be made, and notify individuals of their rights and the agency's legal duties with respect to PHI.
- C. A copy of the Privacy Notice/Notice of Privacy Practices will be posted in a clear and prominent location where it is reasonable to expect individuals seeking service from the agency will be able to read the notice.
- D. The Notice of Privacy Practices will be posted on the agency's website. The notice on the website will reflect the most recent version.



- E. The Stark County Health Department will promptly revise its Privacy Notice whenever there is a change to the uses or disclosures, the client's rights, the agency's legal duties, or other privacy practices described in the Privacy Notice. A revised Privacy Notice shall be available upon request on or after the effective date of the revision. If a written acknowledgment was previously obtained or a good faith effort documented, another written acknowledgment is not required when the Privacy Notice is revised. In addition, the revised Privacy Notice will be promptly posted in a clear and prominent location.
- F. Except in an emergency, the privacy notice will be provided to the client or their personal representative no later than the date of the first treatment service delivery.
- G. The Stark County Health Department will make a good faith effort to obtain a written acknowledgement of receipt of the Privacy Notice from the client or his/her legal representative, except in an emergency.
- H. The agency will not refuse to treat a client because he/she would not sign a written acknowledgment; instead, the agency should document the good faith effort to obtain the signature. Documentation of a good faith effort shall include the date the Privacy Notice and acknowledgment was given to the individual and the reason the client refused acknowledgement.

Section 1.5 USE OF PROTECTED HEALTH INFORMATION

A. How Protected Health Information (PHI) Will Be Used

1. PHI will be used for the purposes of treating our clients, obtaining payment for that treatment, and for other health care operations.
2. In general, payment for treatment will permit our office to share PHI with third-party billing services, to bill for services to insurance companies, government programs, or other third-party reimbursement sources.
3. Stark County Health Department and authorized state agency personnel may have access to PHI, without authorization from the client, for the purpose of conducting management, financial, or program evaluations, ascertaining the accuracy of financial, administrative, or medical information, and adhering to financial, legal,



medical, or administrative standards.

4. We will also comply with state law in those situations where disclosure of PHI is required to report incidents of potential criminal activity, abuse or public health disclosures or such other disclosures as may be required by state or federal law.
 - a. Child Abuse-In accordance with O.R.C. 2151.421 health care providers are required to report known or suspected abuse or neglect of a minor or physically or developmentally disabled person to Children's Services
 - b. Elder Abuse- In accordance with O.R.C. 5101.63 an employee of a health department is required to report known or suspected elder abuse, neglect or exploitation of an adult as described in section 5101.60 of the O.R.C. to County Department of Job and Family Services Adult Protective Services division
 - c. Communicable Diseases-O.R.C. 3701.25 requires certain communicable diseases to be reported to the Ohio Department of Health. A public health authority is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority.
 - d. If health department personnel believe a client may likely cause harm to a third party or themselves, they will make a report to law enforcement or crisis intervention.
5. Such other exceptions as are provided by law and in the Notice of Privacy Practices of the Stark County Health Department.
6. We will also use PHI to provide when appropriate, information to our clients concerning the care and treatment of their particular conditions or new developments in medicine that relates to their condition and treatment.



7. We will also disclose PHI in emergencies where such information may be necessary to provide emergency medical care to the client.

B. Release to Legal Representative and/or Immediate Family

1. In certain circumstances, our clients may have other persons serving as legal representative for the client. In cases where the client has a legally appointed representative, or in the case of a minor child, his/her parent, we will be permitted to disclose PHI to such individuals upon reasonable verification of their appointment as legal representative or their position as parent of the minor.
2. We will also ask our clients in advance if we are permitted to disclose or discuss PHI with other persons, they specify such as immediate family members.

C. When releasing PHI over the phone to physicians for the purposes of treatment and or in person to the client, a signed release is not necessary.

1. Immunization records will be disclosed to physicians via phone on representation by the physician that they are the treating physician of the patient and will maintain confidentiality of the information.

D. Revocation of Authorizations

1. At any time, the client in writing or verbally may withdraw their consent to release or discuss PHI to third parties and, any such withdrawal will be noted on the client record.

E. Complying with Minimum Necessary Standards

1. Disclosures of PHI will be limited to the minimum necessary for the purpose of the disclosure, unless we receive an authorization from the client. This provision does not apply to the disclosure of PHI for treatment purposes because physicians, specialists, and other providers need access to the full record to provide quality care. The minimum necessary standard requires that providers make all reasonable efforts to limit the PHI to the minimum necessary to accomplish the purpose of use or disclosure.

F. Incidental Use and Disclosure



1. Uses and disclosures that are incidental to an otherwise permitted use or disclosure may occur, if reasonable safeguards and minimum necessary requirements have been met.
2. This specifically means that our office may use waiting room sign-in sheets; doctors can talk to clients in semi-private rooms, and doctors can confer at nurse's stations without fear of violating the rule if a passerby overhears PHI.

G. PHI may be received via email for the purposes of coordinating treatment only using the Ohio Department of Health or another department/agency secure health information exchange. All other emails containing PHI are prohibited. PHI should only be sent via ENCRYPTED email.

I. How PHI Will Not Be Used

1. PHI will not be used for purposes that are not related to health care - such as disclosures to employers to make personnel decisions, or to financial institutions without written authorization from the client.

J. Psychotherapy Notes

1. The treating physician should review psychotherapy notes prior to release and the treating professional may withhold release of notes if they believe the release may be detrimental to the best interest of the patient. The notes themselves may not be released although a general description or treatment diagnosis may be used for purposes of payment or health care operations.

K. Disclosure of HIV Test Results or a Diagnosis of AIDS or HIV follow ORC 3701.243

(A) Except as provided in this section or section 3701.248 of the Revised Code, no person or agency of state or local government that acquires the information while providing any health care service or while in the employ of a health care facility or health care provider shall disclose or compel another to disclose any of the following:

- (1) The identity of any individual on whom an HIV test is performed;
- (2) The results of an HIV test in a form that identifies the individual tested;
- (3) The identity of any individual diagnosed as having AIDS or an AIDS-related condition.



(B)

(1) Except as provided in divisions (B)(2), (C), (D), and (F) of this section, the results of an HIV test or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be disclosed only to the following:

(a) The individual who was tested or the individual's legal guardian, and the individual's spouse or any sexual partner;

(b) A person to whom disclosure is authorized by a written release, executed by the individual tested or by the individual's legal guardian and specifying to whom disclosure of the test results or diagnosis is authorized and the time period during which the release is to be effective;

(c) The individual's physician;

(d) The department of health or a health commissioner to which reports are made under section 3701.24 of the Revised Code;

(e) A health care facility or provider that procures, processes, distributes, or uses a human body part from a deceased individual, donated for a purpose specified in Chapter 2108. of the Revised Code, and that needs medical information about the deceased individual to ensure that the body part is medically acceptable for its intended purpose;

(f) Health care facility staff committees or accreditation or oversight review organizations conducting program monitoring, program evaluation, or service reviews;

(g) A health care provider, emergency medical services worker, or peace officer who sustained a significant exposure to the body fluids of another individual, if that individual was tested pursuant to division (E)(6) of section 3701.242 of the Revised Code, except that the identity of the individual tested shall not be revealed;

(h) To law enforcement authorities pursuant to a search warrant or a subpoena issued by or at the request of a grand jury, a prosecuting attorney, a city director of law or similar chief legal officer of a municipal corporation, or a village solicitor, in connection with a criminal investigation or prosecution.



(2) The results of an HIV test or a diagnosis of AIDS or an AIDS-related condition may be disclosed to a health care provider, or an authorized agent or employee of a health care facility or a health care provider, if the provider, agent, or employee has a medical need to know the information and is participating in the diagnosis, care, or treatment of the individual on whom the test was performed or who has been diagnosed as having AIDS or an AIDS-related condition.

This division does not impose a standard of disclosure different from the standard for disclosure of all other specific information about a patient to health care providers and facilities. Disclosure may not be requested or made solely for the purpose of identifying an individual who has a positive HIV test result or has been diagnosed as having AIDS or an AIDS-related condition in order to refuse to treat the individual. Referral of an individual to another health care provider or facility based on reasonable professional judgment does not constitute refusal to treat the individual.

(3) Not later than ninety days after November 1, 1989, each health care facility in this state shall establish a protocol to be followed by employees and individuals affiliated with the facility in making disclosures authorized by division (B)(2) of this section. A person employed by or affiliated with a health care facility who determines in accordance with the protocol established by the facility that a disclosure is authorized by division (B)(2) of this section is immune from liability to any person in a civil action for damages for injury, death, or loss to person or property resulting from the disclosure.

(C)

(1) Any person or government agency may seek access to or authority to disclose the HIV test records of an individual in accordance with the following provisions:

(a) The person or government agency shall bring an action in a court of common pleas requesting disclosure of or authority to disclose the results of an HIV test of a specific individual, who shall be identified in the complaint by a pseudonym but whose name shall be communicated to the court confidentially, pursuant to a court order restricting the use of the name. The court shall provide the individual with notice and an opportunity to participate in the proceedings if the individual is not named as a party. Proceedings shall be conducted in chambers unless the individual agrees to a hearing in open court.

(b) The court may issue an order granting the plaintiff access to or authority to disclose the test results only if the court finds by clear and convincing evidence that the plaintiff has demonstrated a compelling need for disclosure of the information that cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for disclosure against the privacy



right of the individual tested and against any disservice to the public interest that might result from the disclosure, such as discrimination against the individual or the deterrence of others from being tested.

(c) If the court issues an order, it shall guard against unauthorized disclosure by specifying the persons who may have access to the information, the purposes for which the information shall be used, and prohibitions against future disclosure.

(2) A person or government agency that considers it necessary to disclose the results of an HIV test of a specific individual in an action in which it is a party may seek authority for the disclosure by filing an in-camera motion with the court in which the action is being heard. In hearing the motion, the court shall employ procedures for confidentiality similar to those specified in division (C)(1) of this section. The court shall grant the motion only if it finds by clear and convincing evidence that a compelling need for the disclosure has been demonstrated.

(3) Except for an order issued in a criminal prosecution or an order under division (C)(1) or (2) of this section granting disclosure of the result of an HIV test of a specific individual, a court shall not compel a blood bank, hospital blood center, or blood collection facility to disclose the result of HIV tests performed on the blood of voluntary donors in a way that reveals the identity of any donor.

(4) In a civil action in which the plaintiff seeks to recover damages from an individual defendant based on an allegation that the plaintiff contracted the HIV virus as a result of actions of the defendant, the prohibitions against disclosure in this section do not bar discovery of the results of any HIV test given to the defendant or any diagnosis that the defendant suffers from AIDS or an AIDS-related condition.

(D) The results of an HIV test or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be disclosed to a federal, state, or local government agency, or the official representative of such an agency, for purposes of the Medicaid program, the Medicare program, or any other public assistance program.

(E) Any disclosure pursuant to this section shall be in writing and accompanied by a written statement that includes the following or substantially similar language: "This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses."



(F) An individual who knows that the individual has received a positive result on an HIV test or has been diagnosed as having AIDS or an AIDS-related condition shall disclose this information to any other person with whom the individual intends to make common use of a hypodermic needle or engage in sexual conduct as defined in section 2907.01 of the Revised Code. An individual's compliance with this division does not prohibit a prosecution of the individual for a violation of division (B) of section 2903.11 of the Revised Code.

(G) Nothing in this section prohibits the introduction of evidence concerning an HIV test of a specific individual in a criminal proceeding.

Amended by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013.

Effective Date: 03-23-2000

K. Use of client photos

1. Instead of actual client photos for marketing and advertising, the agency will use generic photos or illustrations in lieu of actual client photo to protect the privacy of our clients.

L. Patient Records Documenting Alcohol or Drug Treatment

1. Federal law provides for the confidentiality of alcohol and drug treatment records and such information may not be released without a specific written client authorization.

1.6 CLIENT ACCESS TO PROTECTED HEALTH INFORMATION

- A. Clients have the right to request a copy of their PHI. Clients will need to sign a release in order to receive a copy of their record to keep on file at the health department. Clients will need to verify their identity through use of a picture ID or social security number before receiving a copy.
1. The health department receives many calls for immunization records. The staff member will verify the caller is indeed the client or legal representative of the client by verifying the client's name, address, date of birth and/or social security number.



2. If the client requests a copy of their PHI, the Department may charge a reasonable copy fee for copies of their PHI in accordance with the published rates of the Ohio Department of Health. If the PHI is maintained in an electronic form, the clients upon request may obtain their copies in an electronic form such as disk or flash drive, but the records will not be emailed. Copy charges for electronic copies will be similar to the charges if they were photocopied and include the reasonable cost of creating the electronic copy.
- B. In the event a client desires to review his/her PHI, the client will be given the opportunity to review the record.
- C. When the review is requested, a date and time will be scheduled for the review, the file must be reviewed in the presence of an employee of the SCHD, and no material in the file will be permitted to be removed or altered. If a client desires to modify the medical record in any way, he/she will be given the opportunity to submit additional information explaining the reason for the requested revision and which information will be included in the official record.
- D. Special Note for Psychotherapy Notes. The patient may not have access to psychotherapy notes except when the doctor has reviewed such notes and has made a determination that the release of such notes will not be detrimental to the patient requesting access to such information, or unless an exception is otherwise available.

1.7 RIGHT TO REQUEST PRIVACY RESTRICTIONS FOR PROTECTED HEALTH INFORMATION

- A. Each client has the right to object to, and request restrictions on, how his /her Protected Health Information (PHI) is used, or to whom the information is disclosed.
 1. Clients can make such requests/objections even if the restriction affects the clients' treatment or payment for that treatment or other health care operation activities.
- B. The Stark County Health Department is not required to agree to any requested restrictions. However, if a restriction is agreed to, it is binding and the agency may not use or disclose PHI in violation of the agreement, unless otherwise allowed or required under other Stark County Health Department policies.



1. For example, an agency may disclose PHI to permit emergency treatment
 2. An agency is also not bound by restrictions when a disclosure is required by law.
- C. If the restriction is agreed to, the following procedure must be implemented:
1. The agency must honor the restriction;
 2. The restriction must be communicated to the agency staff in an approved manner;
 3. Documentation of the approved request must be provided to the client.
- D. If the request for restriction is denied, the following procedure must be implemented:
1. The agency's denial of the request shall be documented according to agency requirements.
 2. Documentation of the denied request must be provided to the client.
- E. The Stark County Health Department may terminate an agreement to a restriction at any time.
1. If the client agrees to the termination by the agency, previously restricted information may be used or disclosed as if a restriction never existed.
 2. If a client objects to the termination, the termination is still in effect, but only with respect to the PHI created or received after the client is informed of the termination of the restriction.
- F. The Client's Right to Restrict Disclosure of Portions of Their PHI
1. A client may ask the Stark County Health Department not to disclose a part of their medical information to others if the client has paid for the service related to the that treatment in full when the Stark County Health Department may otherwise have billed an insurance company or other persons for such medical services. If requested, and provided not contrary to law, we will segregate that portion of the medical record and specifically note it is to be separate to prevent



an inadvertent disclosure of that information if the record is copied and sent pursuant to an authorization or otherwise.

- H. The Stark County Health Department will not disclose any PHI for marketing purposes or sell any such information to other parties, except as expressly permitted by law.

1.8 RIGHT TO REQUEST AMENDMENT TO PROTECTED HEALTH INFORMATION

- A. Each client has the right to request in writing amendments of his/her PHI for as long as the information is maintained by the agency. It will be our policy not to delete or change any notation or component of the medical records maintained by us, but will include by insertion additional comments from the client.
- B. Each client request for amendment to his/her PHI must be in writing and must include the reason for requesting amendment (See sample form in Appendix).
- C. If the agency grants the amendment in whole or in part, the following steps must be taken:
 - 1. Identify all documents that need to be amended.
 - 2. Allow insertion of the amendment as an addendum to the contested portion of the PHI; however, the original portion of the PHI may not be deleted.
 - 3. Inform the requester that the amendment is accepted and obtain the client's identification of an agreement to have the agency notify the relevant persons with which the amendment needs to be shared.
 - 4. Make reasonable efforts to inform and provide the amendment within a reasonable time to those identified by the client and to any business associates who have copies of the PHI being amended.
- D. Stark County Health Department may deny a request to amend a client's PHI if the agency determines that the information;
 - 1. Was not created by the agency (or the originator of the information is no longer available to evaluate the request for amendment);



2. Is not part of the PHI;
 3. Is inaccurate and incomplete.
- E. Stark County Health Department will provide a timely, written denial to a client that is written in plain language and contains the following elements:
1. The basis for the denial;
 2. The client's right to submit a written statement disagreeing with the denial and how the client may file such a statement;
 3. A statement that if the client does not submit a statement of disagreement, the client may request that the agency include the client's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.
- F. If a client requests review of the denial to amend PHI, the agency will designate a different individual to review the decision to deny.
- G. The agency will promptly provide written notice to the client of the determination made by the reviewing official.
- H. If amendment to PHI is again denied in whole or part, the licensed health care professional is required to comply with the requirements listed below.
1. Provide the client with a written explanation as to the reason for the denial.

1.9 DISCLOSURE OF PROTECTED HEALTH INFORMATION WITH AUTHORIZATION

- A. Disclosure of Protected Health Information (PHI).
1. PHI will only be released for purposes other than treatment, payment or operations with the written authorization of the client, except as required by law or as authorized under the privacy practices of the Stark County Health Department.



B. Examples of Situations Where an Authorization May Be Required.

1. The client is treated for a medical condition and requires a letter from the agency of such treatment in order to return to work with credit for a sick day. A letter cannot be sent to the employer without a written authorization from the client given in advance.
2. The client is examined in an independent medical examination for a workers' compensation claim. The medical report cannot be given without a written authorization signed by the client in advance.
3. A written request is submitted to the office by an attorney for the client for PHI in a personal injury lawsuit. The PHI cannot be duplicated and released to an attorney without a written authorization signed by the client in advance.
4. The client agrees to be interviewed by local media for a story on a public health related matter. If the client signs a release, the agency may release the client's name, address, and phone number to local media so the media can contact them for an interview.

C. A sample authorization form can be found in the Appendix. The authorization must be in writing and a copy of the authorization will be provided to the patient. The client can revoke the authorization at any time.

D. Minors or Incompetent Clients

1. Authorization to release medical information regarding a minor or an incompetent client of any age must be provided by a parent of the minor, or a legally appointed representative of the minor or incompetent client. An exception to this requirement is in certain circumstances where a minor may give his/her own consent. In such a situation, he/she is the only person who may authorize a disclosure regarding that portion of the PHI (For example: Minors seen in STD Clinic or for HIV testing).

E. A written authorization, where required, must include the following information:

1. Name of the Stark County Health Department as the releasing agency



2. Title of the person or organization receiving the information
 3. Client's name
 4. Extent or nature of the information (specific dates if possible) to be released, including a specific request for any HIV information to be released.
 5. A statement that the authorization may be revoked at any time, but not retroactively, and a specific date, event or condition upon which the authorization will expire unless revoked earlier.
 6. Date the authorization is signed
 7. Signature of the client or his/her legally authorized representative with relationship noted.
- F. Release procedures when authorized by the client.
1. Obtain authorization prior to the release of information. Verify the validity of authorization. A driver's license, social security card or other recognized form of proof of identity shall be required before releasing any PHI to a client/legal representative. Specific guidelines are applicable to the release of HIV test result information. A request for the release of such information should be referred to the Director of Nursing Services/Nursing Unit Manager.
 2. Requests for PHI shall be referred to the appropriate program supervisor. The supervisor will insure all PHI is complete prior to release. All copying of PHI information for release must be coordinated with the appropriate program supervisor.
 3. An employee who is uncertain about the appropriate response to a request for PHI will refuse to release that information until the employee has consulted his/her supervisor or the privacy officer. Employees will be aware of and responsive to time constraints in responding to subpoenas.
 4. The employee releasing PHI from a client record is required to document in the record the following:



- a. The date the PHI is released
- b. The names of the persons and/or agencies receiving the PHI
- c. The specific PHI released
- d. A copy of the completed authorization form shall be sent with the PHI requested and/or to the agency from which PHI is requested. The original form shall remain in the client's record.
- e. This record will satisfy the accounting responsibilities under HIPAA and will be available upon request.

G. Mailing of PHI

1. PHI mailed to someone other than a medical provider, institution or other recognized service provider or agency will be sent via registered mail, receipt required.

H. Faxing of PHI

1. Requests from clients with an appropriate authorization to fax Protected Health Information (PHI) to medical providers, institutions or other recognized service providers or agencies will be honored.
2. The cover sheet used in faxing documents must indicate the confidential nature of the transmission and contain directions as to how the faxed materials are to be handled in the event they are inappropriately received.
3. The original cover letter used in faxing the PHI with a notation of the disclosed information, date, and identity of the employee making the disclosure must be filed in the client's medical record. The signed authorization from the client or the client's legal representative, if available, will be attached.

I. Disclosure of HIV Test Results or a Diagnosis of AIDS or HIV



1. O.R.C. 3701.243 prohibits health care providers and state agencies from disclosing the following information without specific written client authorization. A general medical release is not sufficient.
 - a. The identity of an individual on whom an HIV test is performed
 - b. The results of an HIV test (unless anonymous)
 - c. The identity of any individual diagnosed with AIDS or ARC
2. Any disclosure of HIV or AIDS information shall be in writing and must be accompanied by the following written statement:
 - a. "This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to who it pertains, or as otherwise permitted by state law. A general authorization is not sufficient for the purpose of the release of HIV test results or diagnosis."

J. Disclosure of Patient Records for Alcohol and Other Drug Treatment

1. Public Health Service act (42 USC 290dd-3 and Title 42 CFR Part No. S) Restricts the disclosure and use of PHI about individuals with substance abuse issues or treatment. Disclosures of information of substance abuse diagnosis or treatment requires a specific written client authorization. A general medical release is not sufficient.

1.10 RESPONDING TO A SUBPOENA

- A. Document the circumstances of receipt (i.e. date, time, and manner of service, person served).
- B. Notify your supervisor of the receipt of the subpoena. The supervisor will review the subpoena for required information and time for compliance. Determine whether client has signed authorization (authorization should accompany subpoena).



- C. If the subpoena is not accompanied with an authorization, the supervisor will immediately contact the Director of Nursing who will notify the prosecutor's office and request a motion to quash the subpoena.
- D. If the subpoena and authorization are valid, compile and review material responsive to subpoena.
 - 1. Do not produce information not within scope of subpoena.
- E. Copy the materials and prepare a certification.
 - 1. Contact counsel to ensure that copies are acceptable in lieu of originals.
 - 2. Make notes of materials produced for records.
- F. Comply with the subpoena
 - 1. If only the record is required and not an appearance by a specified individual, send the documents with certification within time specified.
 - 2. If a specified individual is required to attend, bring copies of record together with certification (ensure that copies are acceptable in lieu of originals).

1.11 ACCOUNTING FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- A. The Stark County Health Department will keep a record of any disclosure of Protected Health Information (PHI), which is made for other treatment, payment, or practice operations. The Stark County Health Department will also account for disclosure of PHI which was disclosed electronically for any purposes. No accounting, however, will be required for the release of PHI, which was done in a paper or non-electronic format for billing or medical treatment purposes, except as otherwise required by law.
- B. A record of the disclosure of PHI will be maintained for (a) any disclosure that was electronic or (b) if the disclosure was in paper form, for reasons other than medical treatment, billing, or operations. For example, a return to work letter must be noted. An independent medical examination report must be noted.



- C. A list of all PHI disclosures will be kept in the patient's chart (See Sample Accounting of Disclosures Form in Appendix). Such lists will be maintained for a minimum of six years or reduced to three years if the records were generated from electronic medical records). If the disclosure was made electronically using electronic medical records systems, an appropriate log or other system accounting device will be used to track the disclosures of PHI and will include in the listing the date of disclosure, the name and address of the person to whom the PHI was sent, a brief description of the PHI disclosed, and the purpose for which the PHI was disclosed. A copy of the authorization for the disclosure will be included in the chart.
- D. Each client has a right to receive an accounting of disclosures of his/her PHI made by the agency at any time during the previous six years or for three years if generated electronically. Such requests may not include dates prior to April 14, 2003. This includes any disclosures made to or by any business associate of the agency. An accounting of disclosures made in paper form will be provided to the client, but disclosures of the following type do not have to be included on the accounting of disclosures:
 - 1. Disclosures to the client;
 - 2. Disclosures made based upon signed authorization of the client or personal representative;
 - 3. Disclosures for purposes of treatment, payment, or health care operations.
- E. Stark County Health Department shall require requests for accounting of disclosures to be in writing and forwarded to the appropriate program supervisor for action.
- F. The Stark County Health Department will provide for a complete accounting of any disclosed information as follows:
 - 1. Date of the disclosure;
 - 2. Name and address of the organization or person who received the PHI;
 - 3. Brief description of the PHI disclosed
 - 4. For disclosures other than those made at the request of the patient, the purpose



for which the information was disclosed and a copy of the request or authorization for disclosure.

- G. Disclosures made to health oversight agencies or law enforcement officials may be temporarily excluded from an accounting if the covered agency has been notified by the oversight agency or law enforcement official that providing an accounting could impede the progress of their activities.

1.12 PRIVACY COMPLAINTS

- A. Privacy complaints will be documented, investigated, and resolved in a timely manner, ensuring clients and other individuals that the agency is committed to protecting the health information that is created, received, and maintained by the agency.
 - 1. Investigations will focus on both the specific privacy complaint and any patterns of similar privacy complaints.
 - 2. Documentation of privacy complaints, investigative efforts, and complaint disposition is considered administrative information and shall be maintained by the Privacy Officer for at least (six) years.
 - 3. Documentation of privacy complaint information shall not be filed in a client's record.
- B. The agency will make every effort to ensure documentation of privacy complaints is accurate and reflects the complainant's concerns.
- C. The Department shall make a good faith effort to have all complaint documentation signed by the client and will use the same procedures for obtaining signatures for privacy complaints as they use to obtain signatures for authorizations. If a client appears in person, the complaint information may be documented by the client or by the Privacy Officer, at which time the client will be requested to sign the documentation. Written documentation received through the US mail, e-mail, or facsimile from the client shall constitute signature. Telephone complaints shall be documented by the Privacy Officer. A copy of the documented complaint shall be sent to the client with a request for signature. Regardless of whether a signed copy of the form is returned by the client, the



sending of a copy constitutes a good faith effort to obtain signature. Investigation of a complaint shall begin immediately following receipt of the complaint.

- D. The Stark County Health Department will not retaliate against any individual for filing a privacy complaint with the agency.

- E. Investigation of Possible Violations

In the event the personnel of the Department should determine that a potential violation of the policies has occurred which could compromise the security or privacy of protected health information, it shall be reported to the Director of Nursing Services who will begin or have another designated person begin an investigation of such event.

- 1. Investigation and Risk Assessment

- a. The person will make inquiries to determine what occurred, who obtained access to the protected information, if the person or persons had an appropriate reason for such access, and determine how an unauthorized person obtained access, if applicable.
- b. The person will conduct a risk assessment to determine whether the events posed a significant risk of financial, reputational, or other harm to the insured. The person, as part of that assessment, will also consider the type and amount of protected health information that was involved in the impermissible use or disclosure.
- c. If the investigation concludes that, the breach was unintentional, made in good faith, and within the scope of general authority, and further confirms that the information was not further disclosed or used, except as authorized by the privacy rules, it is not considered a breach.
- d. If the person concludes that it is an inadvertent disclosure and can confirm that the information was not further used or disclosed in a manner not permitted by the privacy rules, or has confirmed that the unauthorized person could not reasonably been able to retain or keep such information, then such actions will also not be deemed a breach.



- e. If the protected health information was in an electronic form, the information was encrypted, and a disclosure of the information in the encrypted form occurred, with the encryption being one of the forms currently approved by the Secretary, then such disclosure is also not considered a breach.

2. Notices to Individuals:

If after conducting the investigation and risk assessment, it is determined that a breach has occurred, then the person shall prepare a summary of their findings similar to the form attached in the Appendix. As soon as possible, but no later than 60 days after the confirmation of a breach has occurred, we will provide written notice to the client or clients, whose information was disclosed or accessed, including the following information within the Notice:

- a. Description of what happened, the date of the breach, and the date of the discovery of the breach, if known;
- b. A description of the types of protected health information that were involved in the breach, such as name, social security number, address, diagnosis, date of birth, and other types of information;
- c. Steps the insured should take to protect themselves from potential harm by virtue of the breach;
- d. A description of what steps we have taken to investigate the breach, to mitigate harm to the patient, and to protect against future breaches; and
- e. Identify contact procedures for the appropriate person at the Department, including telephone number, mailing address, and email address, if applicable.
- f. The Notices will be sent by first class mail or by electronic mail if the client had given such information to the Department, or if the Department knows that the client has died, the Notice will be sent to the next-of-kin or personal representative of the insured.



3. Substitute Notice

In the event that the Department no longer has current contact information for the client, the Department will take the following steps:

- a. If fewer than 10 clients are involved for which there is out-of-date contact information, then the Department will attempt to reach such clients by an alternate form of written notice, telephone or other means;
- b. In the event that there is insufficient or out-of-date contact information for 10 or more clients, then the Notice shall: (a) be posted on the website for the Department, or (b) included in a conspicuous notice in the major newspaper or broadcast media in the area of the clients and include in such notice a telephone number where clients can contact the department for at least 90 days concerning the situations.

4. Emergency Notice

- a. In the event that a breach has occurred, which we determine in good faith requires more immediate notice; the Department will accelerate the time of giving notice to the client, including telephone or other means.

5. Notification to the Media

- a. In the unlikely event that a breach of unsecured protected health information involves more than 500 clients, then in addition to the notices described above, we will contact prominent media outlets serving our area, providing a general description of the same information provided above, without identifying the specific name of the clients, but describing the circumstances, and contact procedures for the appropriate person at the Department.

6. Notification to the Secretary

- a. In the event a breach has occurred for which notice is required, the Director of Nursing Services will maintain a log or other documentation describing each of the breaches and the steps taken by the Department to



provide notice. In addition, the Director of Nursing Services will report to the Secretary the incident, as required at the U.S. Department of Health and Human Services' website by completing the online notification reports in the categories of 500 or more or less than 500 individuals as provided. The website for these reports is currently:

<https://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html>

Section 1.13 CLIENT INFORMATION SECURITY

A. It is our policy to maintain confidentiality of all clients' information and to adopt security standards to prevent access to such information by unauthorized persons. This includes protecting information stored electronically and in paper form.

B. Administrative Safeguards

1. The SCHD Security Officer will assess potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the Department. The SCHD Security Officer will further implement security measures to reduce risks and vulnerabilities and to protect against reasonable anticipated threats or hazards to the security or integrity of such information, and to prevent unauthorized disclosure of such information.
2. The SCHD Security Officer will further periodically review our records to assure continued updates and compliance, and to respond to any incidents of breaches of security.

C. Physical and Technical Safeguards

All protectable information, which is in an electronic format, will be password protected. Computer systems will be in secure locations and will have an automatic log-off and anti-virus software installed. Only individuals who require access to this protected information will have access to the electronic system. In addition, any private information in paper form will be maintained in secured locations, and only personnel having a reasonable need to access such records will be permitted to do so.



D. Backup and Disaster Plan

Electronically stored information will be backed up on a periodic basis with offsite storage. This material will be in a form permitted to be retrieved in the event of a disaster or other destruction of electronic records. While all records are to be password secured, the SCHD Privacy and Security Officer or their designee will have access to medical records in the event of an emergency.

E. Facsimiles

No confidential client information will be faxed to unknown numbers unless precautions are taken to assure the recipient is known.

F. Medical Files

All clients' records will be maintained in secured areas. Only persons with reasonable need to use the information will be allowed access to such information.

G. Oral Communication

Our employees will be instructed to exercise caution when discussing client-sensitive information in an unsecured area.

H. Training

Specific training will be provided regarding the security measures necessary for compliance with these policies.

I. Audit

The SCHD Privacy and Security Officers will periodically audit and review our systems to verify ongoing compliance with these security standards.

J. Business Associate Agreement

The requirements to implement information will be incorporated in our Business Associate Agreements.

K. Record Destruction



All paper records containing protectable information will be destroyed by shredding or other secured methods. Information in electronic form will contain programs and features that will prevent the ability to access previously deleted data in accordance with the recommendations from our information technology consultants or vendors.

Section 1.14 BUSINESS ASSOCIATE

- A. All of our business associates will have a written Business Associate Agreement (See Sample Business Associate Agreement in Appendix) signed protecting the Stark County Health Department in the event a business associate mishandles protected information.
- B. Business associates may include outside contractors, compliance consultants, attorneys, information technology contractors, third-party billing companies, suppliers, and temporary staffing firms.
- C. All of our business associates must confirm in writing to us that they have a HIPAA compliance plan, which covers the privacy regulations and security standards and further, includes the provisions required by HITECH. The business associate must agree to coordinate investigations of any breaches with us and to take other steps as we may require from time to time protecting the privacy of protected health information. All Business Associates must sign and agree to all provisions in the "Business Associate Agreement". It will be the responsibility of the Unit Manager of Administration and Support Services to insure Business Associate Agreements are completed and on file.

1.15 TRAINING AND EDUCATION

- A. It is our policy to inform our employees and business associates to comply with the privacy policies of the department. We will conduct training programs for all current employees to describe the privacy policies of the agency and the importance of such policies. All new employees will be given an orientation regarding patient privacy within 48 hours of their employment with more detailed training to be conducted within 30 days of such employment, if employed in the Nursing Services Area. We will maintain general training records for employees. The appropriate supervisor will insure training is scheduled for new employees.



1.16 PENALTIES

- A. We believe that the rights of our patients and the protection of their protected health information (PHI) are extremely important. In the event that any employee should violate the policies and procedures of the practice regarding such confidentiality, such employee will be subject to immediate discipline and re-education or based upon the severity of the violation, may be subject to immediate discharge. These repercussions will be explained and disclosed to employees during training sessions.

1.17 AMENDMENTS AND MODIFICATIONS

- A. This procedure manual may be amended or modified based upon subsequent revisions in government regulations or subsequent interpretations of those regulations requiring appropriate modifications.
- B. It is further our policy that to the extent that any state or federal law requires additional protection for the rights of patients and the use of their information, that the more restrictive law will apply. As previously noted, to the extent state law requires disclosure of information, such is our policy to comply with that state law and its mandated disclosures.



7235 Whipple Ave NW North Canton, Ohio 44720 330-493-9928 Fax 330-493-9932

Accounting of Disclosures of Protected Health Information

Client Name			Date of Birth	
Date of Disclosure	Name and Address of Entity Receiving Protected Health Information	Brief Description of Protected Health Information	Purpose of the Disclosure (or attach copy of written request)	Employee Signature



7235 Whipple Ave NW North Canton, Ohio 44720 330-493-9928 Fax 330-493-9932

Authorization for Disclosure of Protected Health Information

Client Name		Date of Birth
Please OBTAIN Information FROM the following:		Please SEND my medical information TO:
Name & Title of Provider/Organization	Name & Title of Provider/Organization	
Street Address	Street Address (or specified fax number)	
City/State/Zip	City/State/Zip	
For the purpose of: ☐ Patient Care ☐ Insurance ☐ Self ☐ Other		
I authorize disclosure of the following protected health information: ☐ Entire Medical Record ☐ Dental Treatment Records ☐ Hemoglobin Test Results ☐ Immunization Record ☐ Laboratory Results ☐ Lead Testing Results ☐ Medication Records ☐ Nurses Notes ☐ TB Test Results ☐ Well Child Exam ☐ WIC Records ☐ X-ray Reports ☐ Other ☐ Name, Address and Phone Number ☐ Animal Bite Report		
If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my <i>initials</i> in the applicable space next to the type of information. _____ HIV/AIDS Information _____ Mental Health Information _____ Drug/alcohol diagnosis, treatment, or referral information		
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 12 months from the date on which it is signed.		
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.		
Signature of Client or Legal Representative		Date
If Signed by Legal Representative, Relationship to Client		
For Office Use		
Identification Verified by the following:		
☐ Picture ID ☐ Social Security Number _____		
Employee Signature _____		Date _____



Business Associate Agreement

This Business Associate Agreement is made and entered into as of the _____ day of _____, 20____, (**"the Effective Date"**) by and between the Stark County General Combined Health District hereinafter referred to as the Stark County Health Department (SCHD) located at:

7235 Whipple Ave NW North Canton, Ohio 44720 and _____,

(An individual/corporation/professional corporation/limited liability company) (**"Business Associate"**), located at _____.

RECITALS

- A. Business Associate provides certain services to the SCHD and, in connection with those services, the SCHD discloses to Business Associate or Business Associate receives on behalf of the SCHD certain individually identifiable protected health information ("PHI") that is subject to protection under the federal health care privacy regulations. 45 CFR §§ 160 and 164, as may be amended from time to time (the "Privacy Regulations"), of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); and the Security Standards issued thereunder;
- B. The parties further wish to protect information as required by the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA)(Pub. L. 111-5); and
- C. The Business Associate understands this information has been disclosed to you from confidential records protected from disclosure by state law. No further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains shall be made. A general authorization for the release of medical or other information is not sufficient for the release of information pursuant to the section. RC 3701.17 (D) and
- D. The parties desire to comply with the Privacy Regulations and Security Standards for the purpose of protecting and ensuring the privacy and confidentiality of PHI belonging to clients of the SCHD.



NOW THEREFORE, for and in consideration of the recitals above and the mutual covenants and conditions herein contained, the SCHD and Business Associate enter into this Agreement to provide a full statement of their respective responsibilities.

SECTION I: DEFINITIONS

1.1 Definitions. Unless otherwise provided herein, terms contained in this Agreement shall have the same meaning as set forth in the Privacy Regulations.

SECTION II: SCOPE AND USE OF PHI

2.1 Compliance Plan. Business Associate represents that it has adopted a HIPAA Compliance Plan, which includes the requirements of HITECH, will be responsible for the training of its employees and agents regarding compliance and will maintain complete records regarding its compliance with the Privacy Regulations and the terms of this Agreement.

2.2 Performance of Agreement. Business Associate, its agents and employees (collectively referred to as "Business Associate") may use PHI solely to perform its duties for the SCHD and only as allowed by the terms of this Agreement and the agreement for services to be performed for the SCHD ("Underlying Agreement"). Business Associate agrees that it will not use or disclose PHI in a manner that violates the Privacy Regulations.

2.3 Safeguards for Protection of PHI. Business Associate agrees that it: (a) will protect and safeguard from any oral and written disclosure all PHI regardless of the type of media on which it is stored (e.g., computer software, paper, fiche, etc.) with which it may come into contact in accordance with applicable statutes and regulations, including, but not limited to the Privacy Regulations and Security Standards; (b) implement and maintain appropriate policies and procedures to protect and safeguard PHI; and (c) use appropriate safeguards to prevent use and disclosure of PHI other than as permitted by this Agreement or as required by law. Business Associate acknowledges that SCHD is relying on the assurances of Business Associate that Business Associate will comply with all applicable laws and regulations, including but not limited to the Privacy Regulations and HIPAA. Business Associate shall promptly notify Practice of any material change to any aspect of its safeguards.

2.4 Investigation. In the event the Business Associate or its subcontractors or agents determine that a potential access or disclosure of PHI has occurred, contrary to the Privacy Regulations, Business Associate will



immediately investigate the incident, conduct a risk assessment, and document its findings. In the event that after the investigation, Business Associate determines that a breach has occurred which does not meet an exception, then and in such event, Business Associate will report that finding to the SCHD as soon as possible, but no later than 30 days after the discovery of the incident. Business Associate and SCHD will jointly determine the nature and form of the notification to the media or the Secretary.

2.5 Costs. In the event that a breach has occurred, the parties agree that the cost associated with notification, compliance and the like, related to breaches under the control of Business Associate, will be at the cost and expense of Business Associate. Business Associate will hold the SCHD harmless from and against any and all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including but not limited to attorney's fees, expert witness fees, cost of investigation, litigation or dispute resolution related to or arising out of or in any manner connected with the improper disclosure or breach by Business Associate or its agents of any PHI.

2.6 Use of Subcontractors or Agents. To the extent Business Associate uses one or more subcontractors or agents to provide services under the Underlying Agreement, and such subcontractors or agents receive or have access to PHI, Business Associate shall indemnify and hold the SCHD harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including but not limited to attorney fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of or in any manner connected with the improper disclosure of PHI by the subcontractor or agent utilized by Business Associate.

2.7 Breach or Misuse of PHI. Business Associate recognizes that any breach of the terms of this Agreement may give the SCHD the immediate right to terminate this Agreement, the Underlying Agreement and/or pursue other available legal action.

SECTION III: AMENDMENT OF PHI

3.1 Amendments Requested by the SCHD Business Associate shall promptly incorporate all amendments or corrections to PHI when notified by the SCHD that such information is inaccurate or incomplete.

SECTION IV: SECURITY STANDARDS

4.1 Security Standards. Business Associate represents that it has adopted policies and procedures to implement the Security Standards under the Regulations, which does include protection steps to: (1) ensure the confidentiality, integrity and availability of all electronic PHI received or transmitted to or from Business



Associate by SCHD; (2) protect against any reasonably anticipated threats for hazards to the security or integrity of PHI that are not otherwise permitted by the Privacy Regulations; and (4) ensure compliance with these policies by its employees and agents.

SECTION V: AUTOMATIC CHANGES AND UPDATES TO THIS AGREEMENT

5.1 HITECH. The parties acknowledge that HITECH includes some modifications of the Privacy Regulations and creates additional obligations of parties who possess PHI. The parties acknowledge that some of these changes have not yet gone into effect and are subject to further guidance to be issued by the Department of Health and Human Services in the future.

The parties acknowledge that this Agreement shall automatically change to incorporate any changes in the Privacy Regulations as required by HITECH that go into effect in the future, and that each party shall be exclusively responsible for updating their own policies and procedures, training staff, and taking additional steps to fully comply with any future changes in requirements announced by the DHHS in the future.

5.2 Although not exclusive and other changes may be required, the parties acknowledge at this time DHHS has indicated changes will be required in the areas of (a) compliance with patient requested restrictions on disclosure of specific health care items for which payments have been made in cash; (b) the requirements to return or destroy PHI under certain circumstances; (c) compliance with the new “minimum necessary” criteria; (d) compliance with the new accounting of disclosures of PHI through electronic health records; (e) providing access to PHI in electronic format upon request; (f) prohibition of the sale or use of PHI for marketing purposes; and (g) procedures to monitor and cooperate in audits by DHHS upon request by Department.

5.3 The parties acknowledge that this agreement shall automatically be updated to require each party to fully comply with the then current version of the rules and regulations as modified from time to time without the necessity of changing this Agreement in writing.

SECTION VI: AVAILABILITY, AUDITS, AND INSPECTIONS

6.1 Availability of PHI. Business Associate agrees that it will: (a) make available PHI in accordance with 45 CFR § 164.524; and (b) make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528. Business Associate will provide such accounting to the SCHD as soon as possible, but at least twenty (20) days from the date of request by the SCHD. Each accounting shall provide: (i) the date of each disclosure; (ii) the name and address of the organization or person who received the PHI; (iii) a brief description of the information disclosed; and (iv) for disclosures other than those made at the request of the subject, the purpose for which the information was disclosed and a copy of the request



or authorization for disclosure. Business Associate shall maintain a process to provide this accounting of disclosures for as long as Business Associate maintains PHI received from or on behalf of the SCHD.

6.2 Access to The Department of Health and Human Services. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by one party on behalf of the other, available to the Secretary of the Department of Health and Human Services, governmental officers and agencies for purposes of determining compliance with 45 CFR §§ 164.500-534.

SECTION VII: TERM AND TERMINATION

7.1 Term. This Agreement shall commence on the Effective Date and will remain effective until terminated ("Term").

7.2 Termination for Improper Use. The SCHD may immediately terminate this Agreement by written notice if the SCHD, in its sole discretion, reasonably suspects that Business Associate has improperly used or disclosed PHI in breach of this Agreement.

7.3 Termination for Inadequate Safeguards. SCHD may immediately terminate this Agreement in writing without penalty if it determines, in its sole discretion, that any of Business Associate's safeguards are unsatisfactory for the protection of PHI.

7.4 Termination After Repeated Violations. The SCHD may terminate this Agreement by written notice if Business Associate repeatedly violates this Agreement or any provision hereof, irrespective of whether, or how promptly, Business Associate may remedy such violation after being notified of the same. In the event of such termination, the SCHD shall not be liable for the payment of any services performed by Business Associate after the effective date of termination.

7.5 Termination of Underlying Agreement. This Agreement will immediately terminate without notice upon termination of the business relationship between the parties.

7.6 Return/Destruction of PHI. Business Associate agrees that, the Business Associate upon termination of this Agreement, for whatever reason, will return or destroy all PHI received from, or created or received by the Business Associate, on behalf of the , regardless of form.

7.7 No Feasible Return/Destruction of PHI. To the extent, such return or destruction of PHI is not feasible; Business Associate shall extend the precautions of this Agreement to the retained information. Business Associate shall remain bound by the provisions of this until all PHI has been returned or otherwise destroyed.



7.8 Effect of Termination. All rights, duties, and obligations established in this Agreement shall survive termination of this Agreement.

SECTION VIII: INDEMNIFICATION AND INSURANCE

8.1 Indemnification. Business Associate shall indemnify and hold the SCHD harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement by Business Associate, and its agents and subcontractors.

SECTION IX: DISCLAIMER

9.1 Disclaimer. THE SCHD MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY BUSINESS ASSOCIATE WITH THIS AGREEMENT OR THE PRIVACY REGULATIONS WILL BE ADEQUATE OR SATISFACTORY FOR BUSINESS ASSOCIATE'S OWN PURPOSES OR THAT ANY INFORMATION IN THE POSSESSION OR CONTROL OF BUSINESS ASSOCIATE, OR TRANSMITTED OR RECEIVED BY BUSINESS ASSOCIATE, IS OR WILL BE SECURE FROM UNAUTHORIZED USE OR DISCLOSURE, NOR SHALL THE SCHD BE LIABLE TO BUSINESS ASSOCIATE FOR ANY CLAIM, LOSS OR DAMAGE RELATING TO THE UNAUTHORIZED USE OR DISCLOSURE OF ANY INFORMATION RECEIVED BY BUSINESS ASSOCIATE FROM SCHD OR FROM ANY OTHER SOURCE. BUSINESS ASSOCIATE IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY BUSINESS ASSOCIATE REGARDING THE SAFEGUARDING OF PHI.

SECTION X: MISCELLANEOUS

10.1 Construction. This Agreement shall be construed as broadly as necessary to implement and comply with the Privacy Regulations, Security Standards, and HITECH. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with the Privacy Regulations.

10.2 Notice. All notices and other communications required or permitted pursuant to this Agreement shall be in writing, addressed to the party at the address set forth at the end of this Agreement, or to such other address as either party may designate from time to time. All notices and other communications shall be mailed by registered or certified mail, return receipt requested; postage pre-paid, or transmitted by hand delivery. All notices shall be effective as of the date of delivery of hand delivery or on the date of receipt, whichever is applicable.

10.3 Modification of Agreement. The parties recognize that this Agreement shall automatically be modified to



account for any changes in Privacy Regulations, Security Standards, or HITECH without the necessity of a written amendment. In the event that either party objects to any such automatic amendment, they shall be required to notify the other party immediately in writing as to such changes which they do not agree to and the other party shall have 20 days to respond to such notice. In the event the parties cannot reach an agreement regarding such items, this Agreement will automatically terminate.

10.4 Transferability. The SCHD has entered into this Agreement in specific reliance on the expertise and qualifications of Business Associate. Consequently, Business Associate's interest under this Agreement may not be transferred, assigned, or assumed by any other person, in completely or in part, without the prior written consent of the SCHD.

10.5 Governing Law and Venue. This Agreement shall be governed by, and interpreted in accordance with the internal laws of the State of Ohio, without giving effect to its conflict of law's provisions.

10.6 Binding Effect. This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective permitted successors and assigns. In the event of the termination of this Agreement, each of the parties acknowledges the ongoing responsibility to maintain the security and privacy of PHI.

10.7 Execution. This Agreement may be executed in multiple counterparts, each of which shall constitute an original and all of which shall constitute but one Agreement.

10.8 Gender and Number. The use of the masculine, feminine or neuter genders, and the use of the singular and plural, shall not be given an effect of any exclusion or limitation herein. The use of the word "person" or "party" shall mean and include any individual, trust, corporation, partnership, or other entity.

10.9 Severability. In the event that any provision or part of this Agreement is found to be totally or partially invalid, illegal, or unenforceable, then the provision will be deemed to be modified or restricted to the extent and in the manner necessary to make it valid, legal, or enforceable, or it will be excised without affecting any other provision of this Agreement with the parties agreeing that the remaining provisions are to be deemed to be in full force and effect as if they had been executed by both parties subsequent to the expungement of the invalid provision.

10.10 Waiver. The failure of either party to this Agreement to insist upon the performance of any of the terms and conditions of this Agreement, or the waiver of any breach of any of the terms and conditions of this Agreement, shall not be construed as thereafter waiving any such terms and conditions, but the same shall continue and remain in full force and effect as if no such forbearance or waiver had occurred.

10.11 Priority of Agreement. If any portion of this Agreement is inconsistent with the terms of the Underlying Agreement, the terms of this Agreement shall prevail. Except as set forth above, the



remaining provisions of the Underlying Agreement are ratified in their entirety.

10.12 Heading. The headings of Articles and Sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning of interpretation of this Agreement.

10.13 Entire Agreement. This Agreement constitutes the entire agreement between the parties with respect to the matters contemplated herein and supersedes all previous and contemporaneous oral and written negotiations, commitments, and understandings related thereto.

IN WITNESS WHEREOF, the SCHD, by and through its duly authorized officer, and Business Associate have caused this Agreement to be executed on the day and year set forth previously.

SCHD: Stark County Health Department

By: _____

Name: _____

Title: _____

Address For Notice:

7235 Whipple Avenue NW
North Canton, OH 44720

BUSINESS ASSOCIATE/Name of Business Associate:

By: _____

Name: _____

Title: _____

Address for Notice:



Notice of Privacy Practices

This notice was revised on April 1, 2023 and is effective immediately
If you have any questions about this Notice please contact:

Privacy Officer- Director of Nursing Services
Stark County Health Department
7235 Whipple Avenue NW
North Canton, OH 44720
(330) 493-9928

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE STARK COUNTY HEALTH DEPARTMENT (SCHD), WHETHER MADE BY THE SCHD OR A BUSINESS ASSOCIATE.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. From time to time, the Secretary of Health and Human Services may make changes in the rules and regulations regarding the use of disclosure of PHI. We will continue to update and modify our privacy practices to remain in compliance with such regulations. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling our office and asking for one at the time of your next appointment or by requesting that a revised copy be sent to you in the mail.

1. How We May Use and Disclose Protected Health Information About You.

Your Protected Health Information ("PHI") may be used and disclosed by SCHD, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to collect payment for your health care bills and to support the operation of the SCHD.

Following are examples of the types of uses and disclosures of your protected health care information that is permitted:

Treatment:

We will use and disclose such portions of your PHI to provide, coordinate, or manage your health care and any related services. This may include the coordination or management of your health care with a third party, including your pharmacist.



We will also disclose PHI to other physicians who may be treating you or with whom we have consulted about your treatment. In addition, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of the SCHD, becomes involved in your care by providing assistance with your health care diagnosis or treatment to SCHD.

Payment:

Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you and may include, but are not limited to, the following: making a determination of eligibility or coverage for insurance benefits; reviewing services provided to you for medical necessity; and undertaking utilization review activities; reports to credit bureaus or collection agencies; and to our attorneys for collection, if necessary. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as-needed, your PHI in order to support the business activities of the SCHD. These activities include, but are not limited to, the following: quality assessment activities; employee review activities; health care or financial audits; training of medical students; licensing activities; and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when the physician/nurse is ready to see you. We may use or disclose your PHI, as necessary, to contact you to discuss your appointment. This contact will include phone notification, voice mail messages, text messaging, email or mailing notices to your home.

We will share your PHI with third party "business associates" that perform various activities (e.g., billing, translation services) for the SCHD.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about the SCHD and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

We will take steps to reasonably secure your PHI in our custody and to have backup systems if PHI is kept in electronic form. We will use our best efforts to secure your PHI, but cannot guarantee the information is secure from all risks of potential wrongdoers.



2. Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that SCHD has taken an action in reliance on the use or disclosure indicated in the authorization.

3. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI then SCHD may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed and only so much information that is minimally necessary under the circumstances.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI 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. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens and you have not already been provided a copy, we will try to obtain your acknowledgment of receipt of the SCHD's Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

4. The Law provides that there is Other Permitted and Required Uses and Disclosures That May Be Made without Your Authorization or Opportunity to Object

SCHD has safeguards to ensure client confidentiality for care and billing purposes except as required by law as mandatory reporters.

We may use or disclose your PHI in the following situations without your consent or authorization. These



situations include the following:

Required By Law: We may use or disclose your PHI to the extent that law requires the use or disclosure.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect or elder abuse, neglect or exploitation. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal or in response to a subpoena, discovery request or other lawful process.

- a. **Law Enforcement:** We may also disclose PHI for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the SCHD,



and (6) medical emergencies (not on the SCHD's premises) where it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Self-Harm: Health information may be disclosed to emergency agencies or crisis intervention when notification is needed to lessen a serious or imminent threat of self-harm.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorize federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and the SCHD created or received your PHI in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or



determine our compliance with the requirements of 45 CFR Section 164.500 et seq.

5. Your Rights

The following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights:

You have the right to inspect and copy your Protected Health Information (PHI). This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that SCHD uses for making decisions about you. You will be charged a reasonable fee if you are requesting copies. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may ask us not to disclose a part of your medical information to others if you have paid for the services related to that treatment in full when we may otherwise have billed your insurance company or other persons for such medical services. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

SCHD is not required to agree to all the restrictions that you may request other than the request not to disclose information to your insurance company for services for which you have already paid in full. If SCHD believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If SCHD does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with the SCHD.

We will not use or disclose your PHI for marketing purposes or sell any such information to other parties, except as expressly permitted by law.



You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.

You may have the right to have SCHD amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer-if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 but not for periods longer than six years. The right to receive this information is subject to certain exceptions, restrictions, and limitations. If we keep your PHI in electronic form, such as electronic health records, upon request, we will provide an accounting for all disclosures of PHI for any purposes beginning the latter of 2011, if we implement electronic health record systems or when regulations require such disclosure in the future. This does not apply if we do not keep PHI in electronic form.

You have the right to be notified if an unauthorized disclosure has occurred. If an unauthorized disclosure or use of your PHI has occurred. You may have the right to receive a notice from us of the circumstances and the steps taken by us to correct the circumstances or to prevent it from occurring in the future. Under certain circumstances, you would have the right to ask us to destroy any PHI in our possession, subject to our rights to retain certain copies for the protection of the physician.

You have the right to obtain a paper copy of this notice from us.

6. Complaints You may file a complaint with us or with the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer for further information about the complaint process.



Acknowledgment of Receipt of Privacy Practices

Privacy Officer: SCHD Director of Nursing Services
7235 Whipple Ave NW North Canton, OH 44720
(330) 493-9914

I have received the Notice of Privacy Practices of the Stark County Health Department, which informs me of their legal duties and privacy practices with respect to medical information about myself or a person I am responsible for. I also understand that at any time I can request to see or obtain a copy of the Notice of Privacy Practices in the future.

SCHD has safeguards to ensure client confidentiality for care and billing purposes except as required by law as mandatory reporters.

Client/Parent/Guardian Signature

Date

I understand that HIPAA and patient confidentiality laws dictate to this agency with whom any information regarding my minor children or myself can be released to. With this in mind, I am authorizing the Stark County Health Department to release information to:

Spouse/Partner: _____ Children: _____
Parent: _____ Other: _____

over the phone or in person regarding but not limited to appointment times, medical tests, or any other information regarding my child's care or mine.

If I choose to have this person's name revoked, I will provide this in writing to the Stark County Health Department.

I also understand that I need to provide a separate release form for each program/service that I am involved in at the Stark County Health Department and if revoking the name of someone I had allowed information to be released to I must revoke in every program/service.

Client/Parent/Guardian Signature

Date



Request for Accounting of Disclosures of Health Information

Client Name	Date of Birth
Street Address	
City/State/Zip	
Home Phone	Work Phone
Request of Accounting I hereby request an accounting of the disclosure of my health information from this agency's designated record set(s) that was made to persons/agencies outside of the agency from _____ to _____ (not to exceed a six (6) year period of time). I understand that this accounting shall not include the following disclosures: - To me/my personal representative/other persons involved in my care; - To carry out treatment, payment, and health care operations; - Other Disclosures allowed as outlined in our Notice of Privacy Practices - Disclosures that occurred prior to April 14, 2003	
_____ Signature of Client or Legal Representative	_____ Date
_____ If Signed by Legal Representative, Relationship to Client	
This Section for Agency Use Only	
☐ Request APPROVED Agency Requirements: ☐ Provide Client with copy of Accounting of Disclosure form ☐ Ensure disclosures were made after 4-14-03	
☐ Request DENIED Reason for Denial: ☐ No disclosures recorded ☐ Time period specified by Client was prior to 4-14-03	
☐ Request WITHDRAWN	



Investigation of Potential Privacy Breach

Client's Name: _____ Investigator: _____

Date: _____

Description of Event: _____

Who obtained access to PHI: _____

Were they authorized to do so? _____

If not authorized, how did they gain access? _____

Risk Assessment:

Does the disclosure pose a significant risk of financial, reputational or other harm to client? _____

If yes, explain how: _____

How many clients' information was disclosed? _____

Was the disclosure unintentional or accidental? _____

Was the disclosure a "one time" event or is there a risk the same information could be used or disclosed to someone else? _____

Can the person who received the information keep a copy or did they just see the PHI in our records? _____



If the PHI is in electronic form, is the information encrypted and was the disclosure in an encrypted form? _____

Findings discussed with Director of Nursing Services or designee on: _____

Did "breach" (as defined) occur? _____
If yes:

Remedial steps taken: _____

Notice sent to client(s) on: _____

Did breach involve PHI for more than 500 clients? _____

If yes, date media was contacted: _____

Date of notification to Secretary of DHHS: _____

Retain copies of all Notices proved to client, media and Secretary.



Request for Amendment of Protected Health Information

Client Name		Date of Birth
Street Address		
City/State/Zip		
Home Phone		Work Phone
☐ Correction ☐ Addition ☐ Date of Entry to be Amended: _____		
After review of my health information, I feel that the original documentation regarding _____ is inaccurate because _____ Therefore, I am hereby requesting that the following amendment be made to my health information and become an approved attachment to my permanent record. _____ I understand this request applies only to the health information created by this agency and that in order to amend my health information created by another health care provider I must send a separate request to that provider. _____ Signature of Client or Legal Representative Date _____ If Signed by Legal Representative, Relationship to Client		
This Section for Agency Use Only		
☐ Request APPROVED		
Agency Requirements; ☐ Attach ammendment to all appropriate records		
☐ Notify Client of approval		
☐ Notify persons/agencies identified and authorized by Client		
☐ Request DENIED Reason for Denial: ☐ Information was not created by this agency		
☐ Information was not part of a designated record set		
☐ Information is accurate and complete		
☐ Information is not available to Client per federal law		
Agency Requirements: ☐ Provide written denial notice to Client		



☐ Inform Client of right to submit Statement of Disagreement

Employee Signature

Date



HIPAA Staff Member Policy Statement

1. Purpose of Policy

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities have measures in place to insure the confidentiality of patient's Public Health Information (PHI). The Stark County Health Department (SCHD) qualifies as a covered entity and as a provider making it a "hybrid" agency under the HIPAA laws.

2. Policy

All employees will honor their obligation to protect the confidentiality of PHI, and will sign an Employee Confidentiality Statement. By signing the Employee Confidentiality Statement, the employee agrees:

- To follow SCHD policies about disclosure of PHI
- To only access the PHI needed to complete job responsibilities and to not go beyond access granted in his/her job description
- To take reasonable steps to safeguard and protect the confidentiality of an individual's health information
- To report concerns about suspected violations and privacy breaches
- To maintain and protect the privacy and confidentiality of all individuals while he/she is actively employed by the SCHD and after the employment relationship ends

3. Procedure

- Beginning in April 2016, all workforce members will sign the Employee Confidentiality Statement after they have attended a yearly HIPAA training session.
- The signed Employee Confidentiality Statement will be kept in the employee's personnel record.
- If any revisions are made to the Employee Confidentiality Statement, all employees will be asked to sign the revised version.



Employee Confidentiality Agreement

As an employee of Stark County Health Department (hereinafter "SCHD"), and as a condition of my employment, I agree to the following:

1. I understand that I am responsible for complying with the HIPAA policies, which were provided to me.
2. I will treat all PHI received in the course of my employment with the SCHD, which relates to the clients of the SCHD, as confidential and privileged information.
3. I will not access PHI unless I have a need to know this information in order to perform my job.
4. I will not disclose PHI regarding the SCHD's clients to any person or entity, other than as necessary to perform my job, and as permitted under the SCHD Privacy Policies.
5. I will safeguard my computer password and will not post it in a public place.
6. I will not allow anyone, including other employees, to use my password to log on to the computer, and will not use anyone else's password.
7. I will log off of the computer as soon as I have finished using it.
8. I will not use e-mail to transmit PHI unless I am instructed to do so by the Privacy Officer.
9. I will not take PHI from the premises of the SCHD in paper or electronic form without first receiving permission from the Privacy Officer.
10. Upon cessation of my employment with the SCHD, I agree to continue to maintain the confidentiality of any PHI I learned while an employee and agree to turn over any keys, access ids, or any other device that would provide access to the SCHD or its information.

I understand that violation of this agreement could result in disciplinary actions.

Name (print)

Date

Name (signature)

Witness



Consent to Care

Please **Print** Clearly

Date: _____

Patient Information:

Patient Name: _____ Date of Birth: _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I authorize the release of any medical or other information necessary to process this claim. I authorize the payment of medical benefits to the undersigned physician or supplies for services rendered. I understand that all labs sent for processing to an outside lab will be billed to my insurance as applicable. I understand that I will be responsible for any remaining balance or cost that may accrue as a result of my services.

I understand that at any time I can request the Notice of Privacy Practice of the Stark County Health Department, which informs me of their legal duties and privacy practices with respect to medical information about myself or a person I am responsible for.

I consent to treatment for myself or person I am responsible for including any recommended screening or diagnostic tests. I understand that I may not have the same provider at each visit. Services are provided solely on a voluntary basis. For the Reproductive Health & Wellness Clinic, receipt of family planning is not a prerequisite to receive any other services offered by this site.

Client/Parent/Guardian Signature

Date

I understand that HIPAA and patient confidentiality laws dictate to this agency with whom any information regarding my minor children or myself can be released to. With this in mind, I am authorizing the Stark County Health Department to release information to _____ over the phone or in person regarding but not limited to appointment times, medical tests, or any other information regarding my child's care or mine. If I choose to have this person's name revoked, I will provide this in writing to the Stark County Health Department. I also understand that I need to provide a separate release form for each program/service that I am involved in at the Stark County Health Department and if revoking the name of someone I had allowed information to be released to I must revoke in every program/service.

Client/Parent/Guardian Signature

Date



Acknowledgement of Receipt of Privacy Practices and Consent to Care

Privacy Officer: SCHD Director of Nursing Services
7235 Whipple Ave NW North Canton, OH 44720
(330) 493-9914

Please Print Clearly

Date: _____

Patient Information:

Patient Name: _____

Date of Birth: _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of this practice.

I authorize the release of any medical or other information necessary to process this claim. I authorize the payment of medical benefits for services rendered. I understand that all labs sent for processing to an outside lab will be billed to my insurance as applicable. I understand that I may be responsible for any remaining balance or cost that may accrue as a result of my services received.

I have received the Notice of Privacy Practices of the Stark County Health Department, which informs me of their legal duties and privacy practices with respect to medical information about myself or a person I am responsible for. I also understand that at any time I can request to see or obtain a copy of the Notice of Privacy Practices in the future. SCHD has safeguards to ensure client confidentiality for care and billing purposes except as required by law as mandatory reporters.

I consent to treatment for myself or person I am responsible for including any recommended screening or diagnostic tests. I understand that I may not have the same provider at each visit. Services are provided solely on a voluntary basis. For the Reproductive Health & Wellness Clinic, receipt of family planning is not a prerequisite to receive any other services offered by this site.

Client/Parent/Guardian Signature

Date



I understand that HIPAA and patient confidentiality laws dictate to this agency with whom any information regarding my minor children or myself can be released to. With this in mind, I am authorizing the Stark County Health Department to release information to:

Spouse/Partner: _____ Children: _____

Parent: _____ Other: _____

over the phone or in person regarding but not limited to appointment times, medical tests, or any other information regarding my child's care or mine.

If I choose to have this person's name revoked, I will provide this in writing to the Stark County Health Department.

I also understand that I need to provide a separate release form for each program/service that I am involved in at the Stark County Health Department and if revoking the name of someone I had allowed information to be released to I must revoke in every program/service.

Client/Parent/Guardian Signature

Date



Client Request for Confidential Communication

You have the right to request how you want the Stark County Health Department to communicate with you. All reasonable requests will be accommodated.

☐ Phone or Mail
☐ Phone only
☐ Mail only
☐ Encrypted Email
☐ Text Message
☐ Other _____

It is your responsibility to let us know if your address or phone number has changed or you wish to change your communication status.

If there is an urgent matter regarding your lab results or follow up needed, we will attempt to contact you 3 times by your preferred method. If we are unsuccessful in contacting you, a letter will be sent.

If you wish to be a **"Do not contact status,"** please ask about our **"Annie Policy"**

Client/Parent/Guardian Signature

Date

Print Name



Annie Policy

- 1) I _____ Request for Confidential Communication and
Client's Name
because I wish my presence at this clinic to remain confidential, I request to be a "no contact" client and will adhere to the "Annie Policy"
- 2) I understand that as a "no contact" client, if I need to be reached by the clinic, the clinic will either call or send me a letter requesting me to call Annie and I agree to contact the clinic immediately if I receive an "Annie" message.
- 3) I understand that certain positive test results of sexually transmitted diseases are required by law to be reported to local health departments. I also understand that other tests performed today may require follow-up in order to protect my health, such as abnormal pap tests, and I must respond to calls and contact the clinic to arrange all treatment as recommended.
- 4) I understand that Ohio law (ORC 2151.421) requires health providers to report the knowledge or suspicion of abuse or neglect of persons less than 18 years.
- 5) I will not hold the clinic responsible for any break in confidentiality or in harm to my health in the event I do not contact the clinic when requested.

Client Signature

Date of Birth

Witness Signature

Date



Confidentiality Agreement for Outside Agency

Confidentiality Agreement between:

- Stark County Health Department
 - Outside Agency: _____
 - Outside Agency Representative
Name: _____
1. While working at the SCHD professional behavior is expected at all times. Unacceptable language or behavior will not be tolerated.
 2. The agency representative must be knowledgeable of the rules and regulations of the HIPAA Compliance Act and agree to comply with all Health Insurance Portability and Accountability Act (HIPAA) standards and Health Information Technology for Economic and Clinical Health Act (HITECH).
 3. Throughout the experience with the SCHD, the representative may observe or hear Protected Health Information (PHI), which is confidential. The agency representative may not discuss any PHI outside of the experience that infringes on the rights or privacy of any patient or client associated with the SCHD.

Stark County Health Department Representative

Date

Agency Representative Name (Printed)

Date

Agency Representative Signature

Date



Stark County Health Department's Academic and Confidentiality Agreement

Academic and Confidentiality Agreement between:

- Stark County Health Department
- Academic Institution: _____
- Student: _____

The Stark County Health Department (SCHD) is an important facilitator of learning for those students studying nursing, medicine, health education, environmental health, dietetics, public health, social work or other health related fields.

Upon acceptance, it is important to be aware of the following information:

2. A complete list of students and contact information must be received from the academic instructor prior to admittance.
3. The Academic and Confidentiality Agreement must be signed and returned to the department prior to admittance.
4. Regular attendance is expected from all students. Any deviation in the schedule must be immediately reported to the department.
5. The student is expected to be on time for their experience with the department. Any absence must be reported immediately. The SCHD has committed personnel time to the student experience and disruptions in scheduling must be kept to a minimum.
6. The student must report to and communicate regularly with their designated staff member in the department.
7. Student identification from the respective academic institution or ID badge provided by the SCHD is expected to be worn at all times in the department and community settings.
8. While the student is on the SCHD premises adherence to the dress code is required. Professional dress is expected at all times.
9. No concealed weapons may be brought into the SCHD.
10. Hours of operation for Administration and Support Services & Environmental Health Services are Monday through Friday 8:00 am to 4:30 pm. Nursing Services operate from 8:30 am to 4:30 pm with



evening clinics available by appointment Students must exit the building by 4:30 pm unless they have received prior authorization to deviate from this policy.

11. While working at the SCHD professional behavior is expected at all times. Unacceptable language will not be tolerated. The student is expected to know that during their educational experience they are not only representing their institution of learning but this department and the public served within the community.
12. A student form and an evaluation regarding their SCHD experience must be completed prior to the conclusion of their educational experience.
13. The student must maintain satisfactory progress in their educational experience with the department and the specific service units they volunteer. If a student fails to make satisfactory progress or has not adhered to these requirements, the SCHD may immediately terminate the educational experience without notice.
14. References for this educational experience with the department may be requested by the student. The SCHD reserves the right to deny a reference for any student that has not maintained satisfactory progress or failed to adhere to these requirements.
15. The student must be knowledgeable of the rules and regulations of the HIPAA Compliance Act and agree to comply with all Health Insurance Portability and Accountability Act (HIPAA) standards and Health Information Technology for Economic and Clinical Health Act (HITECH).
16. Throughout the educational experience with the SCHD, the student will have access to Protected Health Information (PHI), which is confidential. The student shall not discuss any PHI outside of the educational experience that infringes on the rights or privacy of any patient or client associated with the SCHD.

Stark County Health Department

Date

Signature of Student

Date

Signature of Academic Instructor

Date