Great Falls Clinic's Notice of Privacy Practices

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

Great Falls Clinic is required by law to keep protected health information private. Great Falls Clinic is required to abide by the terms of the Notice of Privacy Practices that is currently in effect. Great Falls Clinic reserves the right to change the terms of this Notice. Great Falls Clinic will post the revised notice and will make it available upon request. This Notice is effective as of April 14, 2003.

Uses and Disclosures of Health Information

Great Falls Clinic may use and disclose your health information for the following purposes:

Treatment
Great Falls Clinic will use and disclose protected health information to provide, coordinate or manage your care. This includes communication and consultation between health-care providers—doctors, nurses, technicians and other members of your medical team. For example, your doctor may disclose your information to a specialist who is treating you.

Payment
Great Falls Clinic uses protected health information to create bills and collect from insurance companies, Medicare and other payers. This includes providing information such as dates of service, symptoms and diagnosis to your insurance company to show that Great Falls Clinic provided medical services to you.

Montana law allows us to disclose information for payment purposes only if we believe the person receiving it will not use or disclose it for another purpose and will take appropriate steps to protect it.

Health-care operations
Great Falls Clinic uses protected health information for its health care operations purposes, including internal activities to monitor and improve patient care, license staff to care for patients, prepare for state and federal regulatory reviews, manage health-care operations and improve health-care services.

Montana law allows us to disclose information for these purposes only if we believe the person receiving it will not use or disclose it for another purpose and will take appropriate steps to protect it.

Contacts with patients
At times, Great Falls may contact you to:
- Provide appointment reminders

- Provide information about treatment alternatives or other information that may be of interest to you
- Disclose health-related benefits or services that may be of interest to you

Fundraising
Great Falls Clinic may contact you to raise funds for Great Falls Clinic. When conducting fundraising activities, Great Falls Clinic may access only your name, address, and dates of service.

Facility directory
Great Falls Clinic is permitted to use your name, location in the facility, condition (in general terms, such as "good," or "fair") in current patient lists. For example, a relative may wish to visit you in the hospital and would need to know your hospital room number. A family member meeting you for an appointment may have forgotten which floor your appointment is on. You can choose to be excluded from these lists. **[NOTE: can likely eliminate for non-hospital settings]**

Individuals involved in care, notification
Great Falls Clinic may disclose relevant protected health information to a family member or friend involved with your care, or handling your bills. If family or friends are present while care is being provided, Great Falls Clinic will assume your companions may hear the discussion, unless you state otherwise. Great Falls Clinic may also share limited protected health information to notify a family member or legal representative of your location, condition or death.

Medical research
Great Falls Clinic may use or disclose protected health information in medical research either with your authorization or when the research has been reviewed and approved by an Institutional Review Board before any medical research study begins, and the IRB determines that there is no more than a minimal risk to your privacy. In some situations, limited information may be used before approval of the research study to allow a researcher to determine whether enough patients exist to make a study scientifically valid.

To avert a serious threat of harm
Great Falls Clinic uses and discloses protected health information to alert appropriate persons of a serious threat to the health or safety of a patient, another person or the public, including in the limited situations in which a mental health professional may have a duty to warn.

Organ and tissue donation
Great Falls Clinic may release protected health information to organizations that handle organ procurement, or organ, eye, tissue donation banks, or other organizations as needed to make organ or tissue donation and transplantation possible. When patients or their families have decided to donate organs or tissues, limited protected health information about the donor is shared.

Military and veterans

Great Falls Clinic may release information about a patient who is a member of the United States Armed Forces if required to do so by law, or with the patient's written authorization. Great Falls Clinic also may release protected health information about foreign military personnel to the appropriate foreign military authority, if required by law or with the patient's written authorization.

Worker's compensation

If you are seen for a worker's compensation claim, Great Falls Clinic may release information related to your claim if you have assigned a claim for those benefits to the insurer.

Public health purposes

Great Falls Clinic may disclose protected health information for public health purposes when required to do so by law. Release to appropriate agencies and authorities may occur for the following reasons:

- To prevent or control disease or injury
- To report births and deaths
- To report maltreatment of a child or vulnerable adult;
- To report to the federal government adverse reactions to medication or safety problems with products
- To notify people of product recalls
- To notify a person exposed to certain types of disease or those at risk for contracting or spreading a disease

Health oversight activities

Great Falls Clinic may disclose protected health information to health-care oversight agencies, where authorized by law. Oversight activities can include licensure, accreditation, audits and investigations. Montana law generally requires that the person receiving the information agrees in writing to remove identifiers as soon as possible and to not further disclose the information except to complete the oversight activity or to report unlawful conduct such as fraud and abuse.

Lawsuits and other judicial proceedings

Great Falls Clinic must disclose protected health information in response to a court or administrative order. Great Falls Clinic must disclose protected health information in response to certain types of subpoenas, discovery requests or other lawful process, provided that the request for information complies with Montana's requirements regarding compulsory process.

Law enforcement activities
Great Falls Clinic may disclose protected health information to law enforcement officials in response to a court order, investigative subpoena, search warrant or a court-issued summons.

Non-medical information may be disclosed:
- To identify a suspect, fugitive or missing person
- About the victim of a crime under certain limited circumstance;
- About a death believed to be a result of criminal conduct;
- About a crime committed on Great Falls Clinic premises

Coroners, medical examiners and funeral directors
Great Falls Clinic may release Protected health information to a coroner or medical examiner when necessary to identify the deceased or determine the cause of death. Release of information to a funeral director may occur when necessary to handle arrangements after death.

National security activities
Great Falls Clinic may release protected health information to authorized federal officials for intelligence, counterintelligence or other national security activities only as required by law. Great Falls Clinic may disclose protected health information to authorized federal officials so they may provide protection to the President or other authorized individuals if required to do so by law.

Other uses and disclosures of your health information will be made only with your written authorization, which may be revoked at any time.

Patients' rights with respect to protected health information

Right to inspect and copy
You have the right to inspect and to request a copy of information maintained in Great Falls Clinic's record about you. This includes medical and billing records maintained and used by Great Falls Clinic to make decisions about your care.

To obtain or inspect a copy of your medical information, submit a written request to the privacy officer at Great Falls Clinic [Entity address]. Great Falls Clinic may charge a reasonable, cost-based fee to cover the expense of providing the copy(ies).

Most patients have full access to inspect and receive a copy the full medical record. On some occasions, Great Falls Clinic may deny a request to inspect and receive a copy some information in the medical record. This may occur if, in the professional judgment of your physician, the information could cause a threat to you or others, or if the information is protected from disclosure as permitted under state law.

If you are denied access to information, you may request a review of the denial. Another licensed health-care professional who was not involved in the original decision within Great Falls Clinic will independently review both the original request and denial. Great Falls Clinic

will comply with the outcome of the independent review. If you are denied access because the information could cause you or someone else harm, Great Falls Clinic must allow examination of your records by a spouse, adult child, parent, or guardian, or by another health care provider chosen by you.

Right to request amendment

You have the right to request that protected health information or information in Great Falls Clinic's record be amended. Submit a written request to amend to the privacy officer at Great Falls Clinic [Entity address]. The request must include a reason to support the amendment. Great Falls Clinic may deny a request for amendment based upon any of the following circumstances:

- The request is not in writing or does not include a supporting reason
- The information you want to change was not created by Great Falls Clinic, and the originator of the information is available
- The information is not part of the designated medical record
- The information in the record is accurate and complete

Denial of a requested amendment

If Great Falls Clinic denies your request for an amendment, Great Falls Clinic will follow a process that allows you to submit your written disagreement to the privacy officer at Great Falls Clinic, or you can ask that your request for amendment and explanation of the denial be included in any future disclosure of the pertinent protected health information. If you submit a statement of disagreement, Great Falls Clinic may write a rebuttal to your statement of disagreement.

Right to an accounting of certain disclosures

You can ask Great Falls Clinic for a list of where Great Falls Clinic has shared your protected health information. This list would provide you with a summary of all disclosures Great Falls Clinic has made that you would not otherwise already know about. The list would not include the following:

- disclosures to carry out treatment, payment and health-care operations within Great Falls Clinic
- disclosures made directly to you (the patient)

To get a copy of the list, submit a written request to the privacy officer at Great Falls Clinic. Your request must state a time period (no longer than six years) and indicate in what form you want to receive the list. The first accounting within a 12-month period is free. For additional accountings, Great Falls Clinic may charge for the costs of providing the list.

Right to request restrictions

You can ask Great Falls Clinic to restrict the use or disclosure of protected health information about you. Your request must be in writing and submitted to the privacy officer at Great Falls Clinic. Great Falls Clinic will carefully consider the request. If you so request, we will not disclose information to a health care provider who has previously provided care to you, for directory purposes, or to family members who could otherwise receive your information.

Right to request alternate methods of communication
You have a right to request that Great Falls Clinic communicate with you in various ways (such as a letter or e-mail) or at a certain location. For example, you may ask that contact occur only at home or only at your place of business. In this situation, you may submit a written request to the privacy officer at Great Falls Clinic specifying the method or location of being requested. We will comply with reasonable requests, but may ask you to provide information about how payment will be handled.

Complaints and Additional Information

If you want to file a concern or complaint about Great Falls Clinic's use or disclosure of protected health information, you can provide the written complaint or concern to the privacy officer at Great Falls Clinic **[NOTE: need to provide address and telephone number for privacy officer]** or the Department of Health and Human Services.

Great Falls Clinic honors your right to file a concern or complaint. Great Falls Clinic will not take action against you for filing a concern or complaint.

For more information about any of Great Falls Clinic's privacy practices, contact the privacy officer at Great Falls Clinic.

[ENTITY NAME]

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in **[Entity]**'s Notice of Privacy Practices. **[Entity]** is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you have received a copy of [Entity]'s Notice of Privacy Practices.

Patient name: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient:

_____

Signature: _____ Date: _____, 20___

[Entity] USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement not obtained: _____

_____

Signature: _____ Date: _____

[ENTITY NAME]
REQUEST FOR ACCESS TO RECORDS

Patient Name: _____

Address: _____

_____

Date: _____

Records Requested:

☐ All records maintained in designated record set (a "designated record set" is the medical and billing records maintained by a health care provider)

☐ Records maintained in a designated record set relating to the following treatment:
_____
_____
_____

☐ Records maintained in a designated record set for the following time period:

Start Date: _____

End Date: _____

☐ I wish receive a summary of the records requested in lieu of the records themselves, or an explanation of the records requested in addition to the records.

I understand that I may be charged a fee for the costs of retrieving and copying records or for preparing a summary or explanation of records, subject to state and federal law.

Signature of Patient or Patient's Representative:

_____

If signed by Patient's Representative, state authority to act on behalf of Patient:

_____

Please submit this request to:

[Name of Contact Person]
[Entity Name]
[Address]
[Phone Number]

[ENTITY NAME]
RESPONSE TO REQUEST FOR ACCESS TO RECORDS

Patient Name: _____

Date: _____

Your request for access to records is:

☐ **Accepted**

- ☐ Requested records enclosed.
- ☐ We will provide the requested records upon receipt of a record copying/retrieval fee of $_____.
- ☐ Accepted in part and denied in part (see reason for partial denial below). To the extent possible, we have provided the records requested.

☐ **Denied** (No Review of Denial Available)

- ☐ You do not have the legal right to access the requested records.
- ☐ The requested records relate to research and you have waived your right to access the records until the completion of the research.

☐ **Denied** (Review of Denial Available)

- ☐ A licensed health care professional has determined that the access requested is reasonably likely to endanger the health or physical safety of you or another person.
- ☐ The records requested refer to another person and a licensed health care professional has determined that the access requested is reasonably likely to cause substantial harm to that other person.
- ☐ The access was requested by the patient's personal representative and a licensed health care professional has determined that the access requested is reasonably likely to cause harm to the patient or another person.

If your request was denied under this section, you have the right to have the denial reviewed by a licensed health professional who did not participate in the original denial decision. In order to request a review of the denial, please contact the individual named below (see contact information below).

☐ **We are unable to accept or deny your request for access at this time**. The reason for the delay is:

_____

_____

We will accept or deny your request by the following date: _____

☐ **We do not maintain the records that are the subject of your request**.

☐ We do not have further information about where you may access the requested records.

☐ The information we have about where you may access the requested records is as follows: _____

_____

In order to request a review of a denial, or to file a complaint, please contact the following individual:

[Contact Person Name]
[Address]
[Phone Number]

You also have the right to file a complaint with the United States Secretary of Health and Human Services.

[ENTITY NAME]
REQUEST FOR AMENDMENT TO RECORDS

Patient Name: _____

Address: _____
_____

Date: _____

I request that my medical records be amended as follows:

Specify records to be amended: _____
_____
_____
_____

Specify requested amendment: _____
_____
_____
_____

Reason for amendment request: _____
_____
_____
_____

Please identify any specific individuals who have received the unamended information and who you believe should receive the amended information if your request is accepted:
_____
_____
_____

Signature of Patient or Patient's Representative:
_____

If signed by Patient's Representative, state authority to act on behalf of patient:
_____

Please submit this request to:

[Name of Contact Person]
[Entity Name]
[Address]
[Phone Number]

[ENTITY NAME]
RESPONSE TO REQUEST FOR AMENDMENT TO RECORDS

Patient Name: _____

Date: _____

Your request for amendment to records is:

☐ **Accepted**. We will notify individuals or entities that we know have received the unamended records and who may rely on the unamended records to your detriment, including any individuals identified by you in your amendment request.

☐ **Denied**. Reason for denial is checked below.

- ☐ We did not create the record that is the subject of your amendment request. If you have information providing a reasonable basis to believe that the originator of the record(s) that you want amended is no longer available to act on your amendment request, please provide us with that information and we will reconsider your amendment request.
- ☐ We do not maintain the record(s) that you want amended as part of a designated record set at **[Entity]**.
- ☐ You do not have the legal right to access the record that is the subject of your amendment request.
- ☐ The record that is the subject of your amendment request is accurate and complete.

☐ **We are unable to accept or deny your request for amendment at this time**. The reason for the delay is _____
_____

We will accept or deny your request by the following date: _____

If your request for amendment was denied, you have the right to submit a written statement disagreeing with the denial. If you do not submit a statement disagreeing with the denial, you may submit a written request asking us to include your amendment request and our denial of the amendment request with any future disclosures of the record that was the subject of your amendment request.

In order to submit a statement of disagreement, request the inclusion of your amendment request with future disclosures of the record, or file a complaint, please contact the following individual:

[Name of Contact Person]
[Entity Name]
[Address]
[Phone Number]

You also have the right to file a complaint with the United States Secretary of Health and Human Services.

[ENTITY NAME]
REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Name: _____

Address: _____
_____

Date: _____

I request an accounting of disclosures made of my protected health information. I understand that the accounting will not include routine disclosures made for treatment, payment, or health care operations purposes, disclosures made to me or my personal representative, incidental disclosures, disclosures made pursuant to an authorization, disclosures made prior to April 14, 2003, and certain other disclosures that are not required to be included in an accounting.

Please provide me with an accounting of disclosures made between _____, 20__ and _____, 20__. I understand that I cannot request an accounting of disclosures made more than six years prior to the date of this request and that disclosures made prior to April 14, 2003 will not be included in the accounting.

I understand that I am entitled to one free accounting in any 12 month period. If I request more than one accounting during any 12 month period, I understand that I may be charged a reasonable, cost-based fee for the accounting.

Signature of Patient or Patient's Representative:
_____

If signed by Patient's Representative, state authority to act on behalf of patient:
_____

Please submit this request to:

[Name of Contact Person]
[Entity Name]
[Address]
[Phone Number]

[ENTITY NAME]
RESPONSE TO REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Name: _____

Date: _____

Your request for an accounting of disclosures is:

☐ **Accepted**. Please see attached accounting.

☐ **Accepted**. Because you have requested more than one accounting in the past 12 months, please submit $_____ in payment of the fee for compiling the accounting. Upon receipt of payment, we will provide you with the accounting.

☐ **We are unable to provide you with an accounting of disclosures at this time**. The reason for the delay is _____

_____

We will provide you with an accounting of disclosures by the following date:

_____

For more information, please contact:

[Name of Contact Person]
[Entity Name]
[Address]
[Phone Number]

[ENTITY NAME]
ACCOUNTING OF DISCLOSURES
NON-RESEARCH

Non-Research Disclosures

1. Date of Disclosure: _____

Name of Person or Entity Receiving Protected Health Information:

_____

Description of Protected Health Information Disclosed:

_____
_____
_____

Basis for Disclosure (or copy of written request for disclosure):

_____
_____
_____

[Note: the information specified above should be provided for each disclosure subject to the accounting request. In the case of multiple disclosures to the same person or entity for a single purpose, list the information once, and then provide the number or frequency of disclosures made during the time period, as well as the date of the last disclosure.]

[ENTITY NAME]
ACCOUNTING OF DISCLOSURES
RESEARCH

Research Disclosures (for research involving 50 or more individuals)

Your protected health information may or may not have been disclosed for the following research purposes. If it is reasonably likely that your protected health information was disclosed for one of the following research purposes, you may request that we assist you in contacting the entity that sponsored the research or the researcher.

1. Name of Research Protocol/Activity: _____

Description of Research Protocol/Activity:

_____

_____

Type of Protected Health Information Disclosed:

_____

_____

Dates or Time Periods in Which Disclosures May Have Occurred:

_____

Date of Last Disclosure: _____

Contact Information for Entity Sponsoring Research: _____

Contact Information for Researcher: _____

[Note: the information specified above should be provided for each research disclosure subject to the accounting request for research involving 50 or more individuals. For research involving less than 50 people, follow the "Non-Research Disclosures" format.]

ACCOUNTING OF DISCLOSURES CHECKLIST

You MUST account for the following types of disclosures:

- ☐ For public health activities (e.g., for disease control, vital statistics reporting, etc.)
- ☐ For FDA-regulated products or activities
- ☐ For purposes of reporting abuse (child abuse, neglect, others as required by state law)
- ☐ For health oversight activities (e.g., to an agency for investigations, licensure and disciplinary actions, etc.)
- ☐ For judicial and administrative proceedings (e.g., in response to a court order)
- ☐ For law enforcement purposes (e.g., reporting gunshot wounds, for identification purposes)
- ☐ Regarding victims of a crime
- ☐ Regarding the reporting crime on the premises
- ☐ Regarding the reporting of crime in emergencies
- ☐ For the provision of information to coroners, medical examiners, and funeral directors
- ☐ For organ, eye, or tissue donation purposes
- ☐ For research purposes (special accounting rules apply in research context)
- ☐ In order to avert a serious threat to health or safety
- ☐ For military/veterans activities (e.g., for armed forces personnel to assure proper execution of a military mission)
- ☐ For protective services of the President, foreign heads of state, etc.
- ☐ For workers' compensation purposes
- ☐ Disclosures to or by business associates for any of the above purposes

You do NOT need to account for disclosures made under the following circumstances:

- ☐ Information has been deidentified
- ☐ For treatment, payment, or health care operations purposes
- ☐ Pursuant to an authorization
- ☐ To the patient or someone involved in the patient's care
- ☐ For a facility directory
- ☐ For national security or intelligence purposes (e.g., to authorized federal officials for lawful intelligence or counter-intelligence)
- ☐ To law enforcement officials/correctional institutions with custody of the patient
- ☐ Disclosure occurred prior to April 14, 2003
- ☐ Disclosure occurred more than six years from the date of the request for accounting
- ☐ Meets the criteria for a limited data set
- ☐ If patient has agreed to suspend the right to an accounting
- ☐ Incidental disclosures (e.g., statements in a waiting room that may have been overheard)

NOTE: THIS IS NOT A LIST OF PERMISSIBLE DISCLOSURES! THIS LIST DESCRIBES THE INSTANCES WHERE HIPAA REQUIRES THAT A PROVIDER ACCOUNT FOR A PARTICULAR DISCLOSURE. WHETHER A DISCLOSURE IS PERMISSIBLE DEPENDS ON STATE LAW AND HIPAA.

[ENTITY NAME]
Authorization for Use and Disclosure of Patient Health Information

I, _____, authorize **[Entity Name]** to use or disclose (as applicable) the following medical information: _____
_____

The information described above may be disclosed to the following recipient(s):
_____
_____

The use or disclosure (as applicable) is for the following purpose(s):

- ☐ At the request of the patient
- ☐ For research purposes
- ☐ Transfer of records to new physician
- ☐ Other, please specify: _____
  _____

I understand that **[Entity Name]** will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, **[Entity Name]** will not provide the treatment if I am unwilling to sign this authorization form.

- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, **[Entity Name]** will not provide the treatment if I am unwilling to sign this authorization form.

I understand that I may revoke this authorization by sending a written request for revocation to **[Entity's Privacy Officer].** If I revoke this authorization, **[Entity Name]** will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when **[Entity Name]** discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

This authorization shall expire on _____.

I understand and agree to the terms of this authorization:

_____ _____
Patient (or Patient Representative) Signature Date

If signed by Patient Representative, state authority to act on behalf of patient:

_____

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Requirements for a valid HIPAA-compliant authorization

All authorizations must have the following elements in order to be considered HIPAA-compliant. If you receive a request for medical records from a third party, make sure that the request has all of the following requirements. If it does not, your release of the information could be a violation of the Privacy Regulations.

☐ A **description of the information to be used or disclosed**. The description must identify the information in a specific and meaningful fashion (e.g., all medical records from 11/01/2001- 3/15/2003).

☐ The **name or specific identification of the person or class of persons authorized to make the requested disclosure** (e.g., individuals at your clinic or organization).

☐ The **name or other specific identification of the person or class of persons to whom your clinic or organization may disclose the information** (e.g., the name of the attorney requesting the information).

☐ A **description of each purpose of the requested disclosure** (e.g., for a lawsuit). It is permissible for the stated purpose to be "at the request of the patient" if the patient has initiated the authorization.

☐ An **expiration date or expiration event**. For example, "12/31/2004" or, if the authorization is for research purposes, "at the end of the research study." If the information is for research, the expiration date may also be stated as "none."

☐ The **patient's signature and the date**. If signed by a personal representative (e.g., a guardian), there should be a description of that person's authority to act on the patient's behalf.

☐ A **statement that the patient may revoke the authorization in writing**, and **<u>either</u>**:

(a) ☐ the exceptions to the right to revoke—such as when the covered entity has already acted upon it—and a description of how the person may revoke the authorization;

<u>or</u>

(b) ☐ to the extent that the information described in letter (a) is in the covered entity's privacy notice, a reference to the privacy notice.

☐ A **statement about the ability or inability of the covered entity to condition** treatment, payment, enrollment, or eligibility for benefits on whether the patient signs the authorization, by stating **<u>either</u>**:

(a) ☐ the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization;

<u>or</u>

(b) ☐ the consequences of the individual's refusal to sign the authorization, when such conditioning is appropriate. For example, a covered entity may condition treatment that is related to a research study on whether the patient signs an authorization permitting the covered entity to disclose the information to the researchers.

☐ A **statement about the potential for the information disclosed pursuant to the authorization to be subject to redisclosure** by the recipient, and that the information will no longer be protected under the Privacy Regulations.

☐ The authorization must be written in "**plain language**." There is no specific standard for making this determination, but if you believe the authorization is unusually difficult to understand, use caution in disclosing information.

BUSINESS ASSOCIATE AGREEMENT
OF
[ENTITY NAME]

EFFECTIVE DATE: April 14, 2003 ("Effective Date")

PARTIES:

[ENTITY NAME] ("Entity")

_____ ("Business Associate")

RECITALS:

A. ENTITY is a **[state] [nonprofit]** corporation organized and operated to provide health care and related services to patients.

B. ENTITY and Business Associate have entered into one or more agreements (collectively, the "Agreement") in which Business Associate agreed to provide certain services to ENTITY, which services may involve Business Associate's receipt, use, disclosure or creation of Protected Health Information on behalf of ENTITY.

C. The parties desire to enter into this addendum to the Agreement (the "Addendum") to reflect their understandings and obligations with regard to Protected Health Information.

NOW, THEREFORE, in consideration of the mutual covenants and promises made by and between the parties, the receipt and adequacy of which is acknowledged, the parties agree as follows:

AGREEMENTS:

ARTICLE 1.
DEFINITIONS

1.1) Catch-All Definition. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy Rule.

1.2) Specific Definitions.

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

(b) Designated Record Set. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR 164.501.

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

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

(e) Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

(f) Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

ARTICLE 2.
OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

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

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

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

2.4) Business Associate agrees to report to ENTITY any use or disclosure of the Protected Health Information not provided for by this Addendum of which it becomes aware.

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

2.6) Business Associate agrees to provide access, at the request of ENTITY, and in the time and manner determined by ENTITY, to Protected Health Information in a Designated Record Set, to ENTITY or, as directed by ENTITY, to an Individual in order to meet the requirements under 45 CFR 164.524. **[note: this section is unnecessary if Business Associate will not have PHI in a Designated Record Set]**

2.7) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the ENTITY directs or agrees to pursuant to 45 CFR 164.526 at the request of ENTITY or an Individual, and in the time and manner determined by ENTITY. **[note: this section is unnecessary if Business Associate will not have PHI in a Designated Record Set]**

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

2.9) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for ENTITY to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

2.10) Business Associate agrees to provide to ENTITY or an Individual, in a time and manner designated by ENTITY, information collected in accordance with Section 2.9 of this Addendum, to permit ENTITY to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

ARTICLE 3.
PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

3.1) Except as otherwise limited in this Addendum, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, ENTITY as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by ENTITY or the minimum necessary policies and procedures of ENTITY.

3.2) Except as otherwise limited in this Addendum, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. **[note: this section is optional]**

3.3) Except as otherwise limited in this Addendum, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached. **[note: this section is optional]**

3.4) Except as otherwise limited in this Addendum, Business Associate may use Protected Health Information to provide Data Aggregation services to ENTITY as permitted by 42 CFR 164.504(e)(2)(i)(B). **[note: include only if Business Associate will provide data aggregation services to ENTITY]**

ARTICLE 4.
OBLIGATIONS OF ENTITY

4.1) ENTITY shall notify Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

4.2) ENTITY shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

4.3) ENTITY shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that ENTITY has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

4.4) ENTITY shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by ENTITY.

ARTICLE 5.
TERM AND TERMINATION

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

5.2) Termination for Cause. Upon ENTITY's knowledge of a material breach by Business Associate, ENTITY shall either:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Agreement if Business Associate does not cure the breach or end the violation within the time specified by ENTITY;

(b) Immediately terminate the Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

(c) If neither termination nor cure are feasible, ENTITY shall report the violation to the Secretary.

[note: opportunity to cure is optional. The Addendum can also provide that ENTITY may terminate Agreement immediately upon breach by Business Associate without providing opportunity to cure breach.]

5.3) Effect of Termination.

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

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

ARTICLE 6.
INDEMNIFICATION; INJUNCTIVE RELIEF

6.1) Indemnification. Business Associate agrees to indemnify, defend and hold harmless ENTITY and its directors, officers, agents, shareholders and employees from and against any and all claims, demands, losses, expenses, costs (including reasonable attorneys' fees), damages and causes of action arising from or relating to Business Associate's breach of this Addendum.

6.2) Injunctive Relief. The parties hereto acknowledge that the remedy at law for any breach of the terms of this Addendum are inadequate and that the damages resulting from such breach are not readily susceptible to being measured in monetary terms. Accordingly, in the event of a breach or threatened breach by Business Associate or any of its subcontractors of the terms of this Addendum, ENTITY shall be entitled to immediate injunctive relief and may obtain a temporary order restraining any threatened or further breach.

ARTICLE 7.
MISCELLANEOUS

7.1) Regulatory References. A reference in this Addendum to a section in the Privacy Rule means the section as in effect or as amended.

7.2) Amendment. The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for ENTITY to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

7.3) Survival. Sections 5.3, 6.1 and 6.2 of this Addendum shall survive the termination of the Agreement.

7.4) Interpretation. Any ambiguity in this Addendum shall be resolved to permit ENTITY to comply with the Privacy Rule.

IN WITNESS WHEREOF, the parties hereto have executed this Addendum in the manner appropriate to each.

[ENTITY NAME]

By:_____
Its:_____
ENTITY

[BUSINESS ASSOCIATE NAME]

By:_____
Its:_____
BUSINESS ASSOCIATE

Plan Amendment Provisions

1) Permitted Uses and Disclosures. **[Name of Plan]** may use and disclose protected health information, as that term is defined at 45 C.F.R. §164.501, to fulfill its obligations under this plan. For example, **[Name of Plan**] may use protected health information to process applications for coverage, evaluate and pay claims, and perform related activities. **[Name of Plan**] may also use and disclose protected health information for the following purposes: **[list all other permitted uses and disclosures of protected health information]** and as otherwise permitted or required by law.

2) Disclosures to Plan Sponsor. Except as set forth in Section 3, **[Name of Plan]** will disclose protected health information to the plan sponsor only upon receipt of written certification that the plan sponsor agrees to:

(a) Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from **[Name of Plan]** agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

(d) Report to **[Name of Plan]** any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) Make available protected health information in accordance with 45 C.F.R. § 164.524;

(f) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. §164.526;

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

(h) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plan available to the Secretary for purposes of determining compliance by the **[Name of Plan]** with the HIPAA Privacy Rule;

(i) If feasible, return or destroy all protected health information received from **[Name of Plan]** that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) Ensure that the adequate separation required by the HIPAA Privacy Rule is established.

3) Summary Health Information. Notwithstanding anything in Section 2 to the contrary, **[Name of Plan]** may disclose summary health information, as described at 45 C.F.R. §164.504, to the plan sponsor, provided the plan sponsor requests the information for the purpose of: (a) obtaining premium bids from health plans for providing health insurance under the plan, or (b) modifying, amending or terminating the plan.