HIPAA Privacy Forms

This document contains forms referred to directly in the HIPAA & Privacy Manual or otherwise commonly used in relation to a HIPAA policy. The document contains the following forms:

- Authorization Form
- Restriction of Use Form
- Medical Record Amendment Request Form
- Confidential Communications Request Form
- Accounting of Disclosures Request Form
- Privacy Complaint Form
- Release to Law Enforcement Form
- Breach Log
- Security Incident Log
- Emergency Access Log
- Disclosure of Patient Information Log
- Facility Maintenance Log
- Hardware Movement Log
- Standard Response Letter

Authorization for Disclosure of Health Information

Patient name: _____

Date of birth: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

I authorize the use or disclosure of the above-named individual's health information as described below, by:

[ENTITY DISCLOSING INFORMATION]

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records
_____ Medical exam
_____ Immunization record
_____ Other (please specify): _____
_____ Lab results/X-ray reports
_____ Consultation reports

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

[RECEIVING ENTITY INFORMATION]

***For the purpose of*:** _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. 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 **365 days**. 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 to receive continued treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of participant or representative **Date**

_____ _____
Name of patient or representative **Description of personal representative's authority**

Restriction of Use or Disclosure of Protected Health Information

I, _____ , request that **[ENTITY NAME]** ("Practice") restricts the use or disclosure of my health information for payment or health care operations in the manner described here:
(Please be specific)

_____

_____

_____

I understand that **Practice** is not required by law to accept my requested restrictions, but if the practice does, **Practice** agrees to abide by the restrictions except in emergency situations or where disclosure is required by law.

I understand that either I or **Practice** may terminate this restriction in writing at any time in the future.

Patient signature: _____

Printed name: _____

Date of birth: _____

Date: _____

Privacy Officer Comments:

☐ Request accepted

☐ Request rejected

Reason: _____

_____

_____

☐ Patient contacted

Medical Record Amendment Request Form

I, _____ , request that **[ENTITY NAME]** change/amend my medical record because:

(*Explain what is to be changed/amended and why.*)

_____
_____
_____
_____

For my medical record to be more complete/accurate, it should say:

_____
_____
_____
_____

Patient signature: _____

Printed name: _____

Date of birth: _____

Date of request _____

Privacy Officer Action/Comments:

Action must be taken within 60 days of the receipt of the request

☐ Request approved without change.

☐ Request denied for the following reason:

- ☐ Information is not part of the designated record set.
- ☐ The information is accurate and complete.
- ☐ Under HIPAA, patient is restricted from accessing or amending this information.

☐ Practice requests a 30-day extension to respond due to: _____

_____

Signature of privacy officer _____

Date: _____

Confidential Communications Request Form

I, _____ , request confidential communication of my health information when When my health information is disclosed on my behalf.

Please use the following address or manner in disclosing my health information to me.

_____
_____
_____
_____
_____
_____
_____

_____ My initials here affirm that failure to disclose my health information in the non-conforming manner stated above could endanger me.

Patient signature: _____

Date: _____

Printed name: _____

Date of birth: _____

Effective date: _____

Privacy Officer Comments:

☐ Agrees to entire request.

☐ Denies part of requested action:

_____

_____

☐ Requires more complete/specific information to assess request.

☐ The practice cannot reasonably accommodate request.

☐ Patient contacted

Signed: _____

Date: _____

Accounting of Disclosure(s) Request Form

I, _____ , request that **[ENTITY NAME]** provide me with an accounting of any and all applicable "non-authorized" uses and disclosures of my protected health information (PHI) between _____ (beginning date) and _____ (ending date).

I would like to limit this request for accounting to include disclosures only pertaining to:

_____

_____

I understand that I may be charged for this information if I have previously requested this information within the last 12 months. I have been informed of the approximate cost of $ _____ and agree to be financially responsible for this charge.

Patient signature: _____

Printed name: _____

Date of birth: _____

Date: _____

Privacy Officer Action/Comments:
(Action must be taken within 60 days of the receipt of the request)

- ☐ Request approved
- ☐ Request denied for the following reason. Health Information was released:
  - ☐ For treatment, payment, or health care operations
  - ☐ To patient
  - ☐ With patient's authorization
  - ☐ For national security purposes
  - ☐ For law enforcement purposes
  - ☐ As part of a limited data set
  - ☐ Prior to April 14, 2003
  - ☐ Incident to an otherwise permitted use or disclosure
- ☐ Request 30-day extension to respond to _____

_____

- ☐ Patient contacted

Signature: _____

Date: _____

Privacy Complaint Form

I, _____ , would like to make a complaint about the privacy practices and/or procedures at **[ENTITY NAME]**. The following is my statement: *(Please include specific details such as specific personnel involved and the date and location of the event of concern to you.)*

Patient signature: _____

Printed name (print): _____

Patient date of birth: _____

Date: _____

Privacy Complaint Form

The HIPAA Privacy Rule at 45 C.F.R. §164.512(f) permits a covered entity to disclose protected health information in response to a law enforcement official's request for such information about an individual for purposes of identifying and locating the individual or who is or is suspected to be a victim of a crime. **[ENTITY NAME]** may disclose the protected health information if the law enforcement official signs the following acknowledgment:

I, _____ (Law Enforcement Officer's Name and Rank), Badge No. _____ of the _____ (Name of the Agency and Jurisdiction, e.g., Department) represent that I am conducting an ongoing investigation regarding potential criminal activity. I am making an official request for the protected health information of _____ (name of patient):

(1) ☐ Who is suspected to be the victim of a crime:

I represent that the patient or patient's authorized representative is unable or unwilling to authorize the disclosure, or it is otherwise impractical for me to seek authorization. ***I represent that the information requested is needed to determine whether a violation of law by a person other than the victim has occurred***. Such information is not intended to be used against the victim. I also represent that immediate law enforcement activity that depends upon this disclosure would be materially and adversely affected by waiting until the patient or the patient's representative is willing or able to agree to the disclosure.

Or

(2) ☐ Whose identity and location I am trying to determine:

I am entitled to the following: (Check all that apply)

- ☐ Name and address
- ☐ Date and place of birth
- ☐ Social security number
- ☐ ABO blood type and rh factor
- ☐ Type of injury
- ☐ Date and time of treatment
- ☐ Date and time of death, if applicable
- ☐ Distinguishing physical characteristics

I am not entitled to any information related to DNA, DNA analysis, medical records or typing/samples/analyses of bodily fluids or tissue.

_____ _____

Law enforcement official requesting disclosure **Date**

Breach Log

Date of breach: _____

Date breach was discovered: _____

Did the breach occur at or by a business associate?

- ☐ Yes
- ☐ No

If yes:

Name of business associate: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Business associate contact name: _____

Business associate contact phone number: _____

Business associate contact email: _____

Approximate number of individuals affected by the breach: _____

Type of breach:

- ☐ Theft
- ☐ Loss
- ☐ Improper disposal
- ☐ Unauthorized access or disclosure
- ☐ Hacking or information technology incident
- ☐ Unknown
- ☐ Other: _____

Where was the breached information located?

- ☐ Laptop
- ☐ Desktop computer
- ☐ Network server
- ☐ Email
- ☐ Another portable electronic device
- ☐ Other
- ☐ Electronic medical record
- ☐ Paper

Type of patient information involved:

- ☐ Demographic information
  - Name
  - Social Security number
  - Address or zip code
  - Driver's license number
  - Date of birth
  - Other identifier

☐ Financial information
- Credit card or bank account number
- Claims information
- Other financial information

☐ Clinical information
- Diagnosis or conditions
- Lab results
- Medications
- Other treatment information

☐ Other

Brief description of the breach (include the location of the breach, a description of how the breach occurred and any additional information regarding the type of breach, type of media and type of protected health information involved in the breach):

_____

_____

Types of safeguards (protective measures) in place prior to the breach:

☐ Firewalls
☐ Packet filtering (router-based)
☐ Secure browser sessions
☐ Strong authentication
☐ Encrypted wireless
☐ Physical security
☐ Logical access control
☐ Anti-virus software
☐ Intrusion detection
☐ Biometrics

Date(s) notice was provided to affected individual(s):

Date first notice was sent:
Month _____ **Day** _____ **Year** _____

Date last notice sent:
Month _____ **Day** _____ **Year** _____

Was substitute notice required? (Substitute notice is required if you lack sufficient or up-to-date contact information for any affected individuals)

☐ Yes ☐ No

Was media notice required? (Media notice is required if a breach involves 501 or more residents of a state or jurisdiction)

☐ Yes ☐ No

What action did the medical practice take in response to the breach?

☐ Security and/or privacy safeguards
☐ Mitigation (actions to lessen the harm of the breach to affected individuals)
☐ Sanctions (against workforce members who violated the policies and procedures)
☐ Policies and procedures
☐ Other: If "other," please describe: _____

Describe in detail any additional actions taken following the breach:

_____

_____

Security Incident Log

Date	Location	Description	Severity Level of Incident 1: Least Serious 5: Most Serious
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5

Emergency Access Log

Use this form to maintain a log of emergency access activities. Identify when emergency access involved emergency responders, such as the fire department, law enforcement or emergency rescue. Also, log events that were the result of a workforce member's abusive activity and the sanctions imposed.

Name of practice _____

City: _____ **State:** _____ **Zip code:** _____

Describe incident		Who Initiated Access?	Emergency Involved		Official
Description	Date		Yes/No	Dept.	

Disclosures of Patient Information Log

Patient name	Date of disclosure	Who received the information?	Description of protected Health information disclosed	Purpose of disclosure	Was the disclosure for research?	Is this one of multiple disclosures that can be grouped?

Electronic Media and Hardware Movement Log

Use this form to check out and track the location of electronic media and devices such as portable computers. You do not need to check out handheld devices or smartphones, but laptops and backup disks must be logged in and out.

Workstation	Static IP Address	Assigned User		Check Out		Initials
		Name	Location	Out	In	

[LETTERHEAD]

[Date]

[Patient name]
[Patient address]

Re: [Denial of Access/Denial of Amendment/Suspension of Accounting/ Denial of Confidential Communication Request/Extension Needed to Comply with Request/Other Matters]

Dear **[Mr./Mrs./** _____ **]:**

[Entity Name] ("Practice") is a "Covered Entity" as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As a Covered Entity, **[Entity Name]** is committed to protecting patient rights by complying with all aspects of HIPAA.

You submitted a **[Name of Request Form]** to Practice on **[Date of Submission]**. After reviewing your request, Practice, will not grant your request at this time for the following reasons **[Enter other matter of business as applicable. For example, if this letter is in response to a patient complaint, indicate that you have received the complaint and are working to resolve the issue or have resolved the issue. Mention the action you took to mitigate the damage, sanctions that were imposed and what you will do to prevent it in the future]**:

[1. State the reason for denial in clear sentences and plain language.]
[2. Consult Practice HIPAA Privacy Manual for acceptable reasons for denial.]
[3. If letter is for an extension, note acceptable extension timelines in Practice HIPAA Manual, note in the letter why the extension is necessary and when the patient can expect documents or a response from Practice.]

Sincerely,

Security & Privacy Officer