

**HIPAA
PRIVACY
COMPLIANCE
FORMS**

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my Protected Health Information as described below.

My Protected Health Information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

The following individual, organization, or class of persons (e.g., group of individuals within the organization) is authorized to use or disclose my Protected Health Information:

The following individual, organization, or class of persons is authorized to receive my Protected Health Information:

The Protected Health Information that may be used and disclosed is as follows:

[Describe in as much detail as possible the Protected Health Information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

My Protected Health Information will be used or disclosed for the following purpose(s):

[Describe the reason for each use and disclosure of the Protected Health Information. If an individual initiates the authorization for his or her own purposes, insert "at the request of the individual. "]

I understand that if my Protected Health Information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my Protected Health Information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification to the Plan's Privacy Officer at the Fund Office, and this revocation will be effective for future uses and disclosures of Protected Health Information. However, I further understand that this

revocation will not be effective: (i) for information that the Plan already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the Plan and, by law, the Plan has a right to contest the coverage.

This authorization expires [identify a specific date or event]:

**Signature of Individual or Personal
Representative:** _____

Date: _____

**Name of Individual or Personal
Representative:** _____

**Description of Personal Representative's
Authority:** _____

COMPLAINT FORM

You should use this form if you believe that the Plan has failed to comply with matters covered in its Notice of Privacy Practices or has failed to comply with its privacy policies as required by Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"). The Plan will not penalize or any other way retaliate against you for filing a complaint.

I. INDIVIDUAL DATA:

INDIVIDUAL'S NAME: _____

PLAN ID NUMBER: _____

ADDRESS: _____

TELEPHONE NO.: _____

II. COMPLAINT:

A. What is the nature of your complaint?

(Please describe the reasons for your complaint in as much detail as you can provide. For example, which provision in the Privacy Notice you believe that the Plan has violated and how the Plan may have committed the violation.)

B. When did the action causing the violation occur?

C. If relevant, identify any persons at the Plan's organization that may have information about your complaint.

Upon completion of this form please return it to the Fund Office:

If you have any questions about this form or matters covered in Plan's Notice of Privacy Practices, please contact the Plan's Privacy Officer at the above address or at the Fund Office.

You certify that the statements made in this complaint are true and correct to the best of your information and belief.

SIGNATURE: _____

NAME OF INDIVIDUAL (Please print) _____

DATE: _____

**REQUEST FOR ACCESS TO PROTECTED HEALTH
INFORMATION**

I. INDIVIDUAL DATA:

INDIVIDUAL'S NAME: _____

PLAN ID NUMBER: _____

ADDRESS: _____

TELEPHONE NO: _____

II. NATURE OF REQUEST FOR ACCESS:

A. I wish: To inspect To have a copy of the following protected health information:

My enrollment records

My payment records

My claims adjudication records

My case or medical management records

Any other protected health information used by my Plan to make medical decisions about me. Please describe:

B. I wish to receive a copy of the requested protected health information in the following format:

Photocopies

Electronic transmission (if available)

Other (if available)

C. I want you to mail the copies of my protected health information to the following address:

I understand that my Plan will charge me for the postage.

III. CONDITIONS GOVERNING THE REQUEST FOR ACCESS:

- A. Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), the Plan and its Business Associates are required to permit a individual to inspect and obtain a copy of his/her protected health information that the Plan or its Business Associates maintain in a "designated record set." Under the Privacy Rule, a designated record set is a group of records maintained by the Plan and its Business Associates that are the medical records and billing records about individuals maintained by or for the Plan and any other records that may be used to make health care decisions about individuals.

- B. The individual is not, however, entitled to inspect or obtain a copy of any psychotherapy notes that the Plan may have, any information the Plan may have compiled in anticipation of or for use in any civil, criminal, or administrative proceeding, and certain other records, even if such records are in a designated record set.

Signature of Individual or Personal Representative: _____

Date: _____

Name of Individual or Personal Representative: _____

Description of Personal Representative's Authority: _____

The individual will be charged \$_____ per page for any copies made and a postage charge if copies are to be mailed to the individual. The Plan will calculate the charge of the individual's request, and notify the individual of the amount due before the Plan processes the request. If the individual chooses not to pay the charge, the request for access will be considered cancelled. There is no charge to the individual to inspect his/her records on the Plan's premises.

PLAN BUSINESS ASSOCIATE TO COMPLETE THE FOLLOWING:

Response to Request for Access

The Plan must respond to an access request within 30 days of its receipt, unless the requested records are off site. The Plan then has 60 days to respond.

Date access request received: _____

Date appropriate Plan units and Business Associates directed to search for requested records: _____

The Plan may take one 30-day extension by notifying the individual in writing within the 30 or 60-day response period of the reason for the extension and the date on which the Plan will provide its response: _____

Extension notice sent on: _____

Response date promised in extension notice: _____

Reason given for extension: _____

Review of Request for Access

The request for access has been reviewed by the Plan/Business Associate and is:

- Accepted Denied

Denial of Request for Access

If denied, is the denial for one of the following *unreviewable* reasons for denial:

- Protected health information is not part of the designated record set.
- The requested information is not maintained by the Plan or its Business Associate(s).
- Federal law forbids making the requested information available to the individual for inspection (e.g., CLIA or Privacy Act of 1974).
- The requested information is psychotherapy notes.
- The requested information has been compiled for legal proceeding in which the Plan is involved.
- The requested information was obtained from someone other than a health care provider under promise of confidentiality and access would be reasonably likely to reveal the source of the information.
- The requested information is temporarily unavailable because the individual is a research participant.

If denied, is the denial for one of the following *reviewable* reasons for denial:

- A licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others.
- A licensed health care provider has determined that the requested *information* identifies a third person who is not a health care provider and that substantial harm is reasonably likely to occur if access to the information is granted.

- O A licensed health care provider has determined that access to the requested information by the individual's legal representative could result in harm to the individual.

Review of A Denial of Request for Access

Individual requested a review of the Plan's denial of access on: _____

A licensed health care professional examined the individual's request for review of a denial of access on: _____

Result of the review is attached. O Yes O No

Request for Access Granted

Access granted on _____ and notice of granted request for access was sent to the individual.

O Records inspected: _____

O Copies supplied: _____ Charges: \$ _____ Paid: _____

O Summary or explanation provided: _____

Charges: \$ _____

Paid: _____

Signature of Plan Business Associate

Representative: _____

Date: _____

**REQUEST FOR AMENDMENT OF PROTECTED HEALTH
INFORMATION**

I. INDIVIDUAL DATA:

INDIVIDUAL'S NAME _____

PLAN ID NUMBER: _____

ADDRESS: _____

TELEPHONE NO.: _____

II. NATURE OF REQUEST FOR AMENDMENT:

A. I wish my Plan to amend the following protected health information: _____

B. I request this amendment for the following reason(s):

C. The information should be amended as follows:

D. I want my Plan to notify the following persons who may have received my protected health information in the past of any amendment to my protected health information:

E. I agree that my Plan may provide my amended protected health information to Business Associates: (i) that the Plan has provided the protected health information, which is the subject of the amendment request, and (ii) from whom my Plan has received the protected health information, which is the subject of the amendment request.

Yes No

III. CONDITIONS GOVERNING THE REQUEST FOR AN AMENDMENT:

A. Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), the Plan and its Business

Associates are required to permit an individual to request an amendment of his/her protected health information that he/she believes is inaccurate or incomplete.

- B. The Plan may deny a individual's request if the protected health information:
1. Is not part of a designated record set (Under the Privacy Rule, a designated record set is a group of records maintained by the Plan and its Business Associates that are the medical records and billing records about individuals maintained by or for the Plan and any other records that may be used to make health care decisions about individuals:);
 2. Was not created by the Plan or its Business Associate(s);
 3. Is complete and accurate;
 4. Constitutes psychotherapy notes;
 5. Was compiled in anticipation of or for use in any civil, criminal, or administrative action or proceeding involving the Plan; or
 6. Not subject to disclosure to the individual under the Clinical Laboratory Improvements Amendments of 1988.

Signature of Individual or Personal Representative: _____

Date: _____

Name of Individual or Personal Representative: _____

Description of Personal Representative's Authority: _____

PLAN BUSINESS ASSOCIATE TO COMPLETE THE FOLLOWING:

Response to Request for an Amendment

Plan must respond to an individual's amendment request within 60 days.

Date of receipt of request: _____

If necessary, the Plan may take one 30-day extension from the date of receipt of the request to provide a response.

Extension notice sent on: _____

Response date promised in extension notice: _____

Reason given for extension: _____

Review of Request for Amendment

Request for correction / amendment has been: Accepted Denied

Request for Amendment Is Accepted

Date the individual notified of the acceptance of the request: _____

Date the persons or entities identified by the individual to receive the amended protected health information were notified of the amendment: _____

Date that the appropriate Business Associates were notified of the amendment:

Request for Amendment Is Denied

The request for amendment was denied for the following reasons:

- The protected health information was not created by the Plan or its Business Associate(s).
- The protected health information is not part of a designated record set.
- The protected health information constitutes psychotherapy notes
- The protected health information is accurate and complete.
- The protected health information is compiled in anticipation of or for use in any civil, criminal, or administrative action or proceeding in which the Plan is involved.
- The protected health information is not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988.

The individual was notified of the denial on: _____

Objection to Denial of Request for Amendment

- O On _____ individual requested that the request for amendment and Plans denial be included in future disclosures of the protected health information. Link or append the request for amendment and Plan's denial of the request to the disputed protected health information. Include the request for amendment and Plan's denial of request, or, in the alternative, a summary of the situation in future disclosures of the disputed protected health information.
- O On _____ individual submitted a statement of disagreement. Link or append the statement of disagreement to the disputed protected health information. Include the statement of disagreement, the request for amendment, and the denial of the request, or, in the alternative a summary of the situation in future disclosures of the disputed protected health information.
- O On _____ the Plan prepared rebuttal to individual's statement of disagreement and sent it to the individual. Link or append the rebuttal statement to the disputed protected health information. Include the statement of disagreement, the request for amendment, the denial of the request, and, the rebuttal, or, in the alternative a summary of the situation in future disclosures of the disputed protected health information.

**REQUEST FOR AN ACCOUNTING OF CERTAIN DISCLOSURES
OF PROTECTED HEALTH INFORMATION**

I. INDIVIDUAL DATA:

INDIVIDUAL'S NAME: _____

PLAN ID NUMBER: _____

ADDRESS: _____

TELEPHONE NO.: _____

II. NATURE OF REQUEST FOR AN ACCOUNTING:

I hereby request to receive an accounting of all disclosures made of my protected health information for reasons other than those expressly excluded from this accounting requirement by the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"). (CHECK ONE):

- All disclosures (that are not excluded) made during the six (6)-year period prior to the date of this request, but not including disclosures made before April 14, 2003.
- All disclosures (that are not excluded) made during the following time period: Through _____ (not to include disclosures made before April 14, 2003).

III. CONDITIONS GOVERNING THE REQUEST FOR AN ACCOUNTING:

A. Under the Privacy Rule, the Plan and its Business Associates are required to provide an accounting of certain disclosures of protected health information to individuals who request the accounting. Specifically, the Privacy Rule *does not require* the Plan to account for the following disclosures:

1. Disclosures made prior to April 14, 2003 (the compliance date for HIPAA Privacy Rule);
2. Disclosures made for purposes of carrying out payment or health care operations;
3. Disclosures made to the individual regarding his/her protected health information;
4. Disclosures made for national security or intelligence purposes;
5. Disclosures made to correctional institutions or law enforcement officials;
6. Disclosures made pursuant to an authorization from the individual or his/her personal representative;
7. Incidental disclosures made pursuant to the Privacy Rule; or
8. Disclosures made as part of a "limited data set" (as defined by the Privacy Rule).

- B. The Plan may temporarily suspend the individual's right to receive an accounting of any disclosures the Plan has made to a health oversight agency or a law enforcement official, if the agency or official has informed the Plan that such an accounting would be reasonably likely to impede the activities of such agency or official.

- C. The individual is entitled to one free accounting for each twelve (12)-month period. For any additional accounting requested within the same twelve (12) month period, the Plan may charge a reasonable fee for copy costs and mailing fees. If facility charges a fee for copy and/or mailing costs, the individual will be provided an estimate of such cost prior to receiving the accounting. If the individual chooses not to pay such costs, the request will be deemed cancelled.

Signature of Individual or Personal

Representative: _____

Date: _____

Name of Individual or Personal

Representative: _____

Description of Personal Representative's

Authority: _____

PLAN BUSINESS ASSOCIATE TO COMPLETE THE FOLLOWING:

Response to Request for Accounting

Plan must respond to an individual's accounting request within 60 days of receipt.

Date request for accounting received: _____

Accounting Period: From: _____ To: _____

If necessary, the Plan may take one 30-day extension from the date of receipt of the request to provide a response.

Extension notice sent on: _____

Response date promised in extension notice: _____

Reason given for extension: _____

- Individual's right to receive an accounting of disclosures made to a health oversight agency or law enforcement official is temporarily suspended pursuant to the written notification received by the Plan from the agency or official. The suspension period expires on: _____

If requested accounting is the second or more accounting requested within the same twelve (12) month period, estimate the charge, if any, for copying and mailing.

Date estimated charge communicated to member: _____

Date member

accepted: _____ rejected charge: _____

Date accounting sent to member: _____

Request for Accounting Is Denied:

The request for accounting is denied for the following reason(s):

- Disclosures made prior to April 14, 2003 (the compliance implementation date for HIPAA Privacy Rule);
- Disclosures made for purposes of carrying out payment or health care operations;
- Disclosures made to individual regarding his/her protected health information;
- Disclosures made for national security or intelligence purposes;
- Disclosures made to correctional institutions or law enforcement officials;
- Disclosures made pursuant to an authorization from the individual or my personal representative;

- O Incidental disclosures made pursuant to the Privacy Rule; or
- O Disclosures made as part of a "limited data set" (as defined by the Privacy Rule).

The individual was notified of the denial on: _____

Signature of Plan Business Associate Representative:

Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I. INDIVIDUAL DATA:

INDIVIDUAL'S NAME: _____

PLAN ID NUMBER: _____

ADDRESS: _____

TELEPHONE NO.: _____

II. NATURE OF REQUESTED RESTRICTION

A. I represent that I *could be endangered if* my Plan fails to communicate my protected health information by an alternative means or at an alternative location. *[Please initial.]* _____

B. I request my Plan or its Business Associate to communicate with me regarding my protected health information in the following alternative manner or method.

At a telephone number other than my home number. The telephone number at which I should be contacted is:

_____.

At a mailing address other than my home mailing address. The mailing address at which I should be contacted is:

_____.

Through my e-mail address, rather than my home address. My e-mail address for purpose of contacting me is:

_____.

Other. Please specify:

_____.

III. CONDITIONS GOVERNING THE REQUEST FOR CONFIDENTIAL COMMUNICATIONS:

Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), a Plan and its Business Associate are required to honor only *reasonable* Requests for Confidential Communications if a disclosure of protected health information could endanger the individual. A Plan/Business Associate may condition granting the request for reasonable accommodation upon the following:

1. The individual providing information concerning how premiums or other payments will be handled; and
2. The individual specifying an alternative address or other method of contact.

INDIVIDUAL SIGNATURE: _____

INDIVIDUAL NAME (Please Print): _____

PLAN/BUSINESS ASSOCIATE TO COMPLETE THE FOLLOWING:

The Request for Confidential Communications has been reviewed by the Plan/Business Associate and is:

Accepted Denied (Request cannot reasonably be accommodated)

Date Restriction Becomes Effective: _____

Comments: _____

Signature of Plan/Business Associate Representative:

Date: _____

**REQUEST FOR RESTRICTIONS ON USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I. INDIVIDUAL DATA:

INDIVIDUAL'S NAME: _____

PLAN ID NUMBER: _____

ADDRESS: _____

TELEPHONE NO.: _____

II. NATURE OF REQUESTED RESTRICTION:

I request my Plan or its Business Associate to restrict the use and/or disclosure of the following protected health information:

- Restrict uses and/or disclosures of protected health information for purposes of payment or health care operations in the following manner:

_____ (e.g., do not use my protected health information to audit Plan's preferred providers)

- Restrict disclosures to a family member, relative, or close personal friend who is involved with my health care. Please specify individual(s) to whom this restriction applies: _____

III. CONDITIONS GOVERNING THE REQUEST FOR RESTRICTIONS:

- A. Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), a Plan and its Business Associate are not required to agree to this Request for Restriction, or they may agree to only a part of the Request for Restriction, while denying agreement to the remaining request.

- B. If the Plan or Business Associate agree to the requested restriction (whether all or in part), then the restriction is in effect until one of the following events occurs:

1. The individual agrees to, or requests in writing, that the restriction be terminated; and
2. The Plan or Business Associate notifies the individual that it is terminating the agreement to restrict the uses and/or disclosures of protected health information.

- C. If the individual agrees to the termination of a restriction, then the individual's protected health information will no longer be subject to the restriction. If the

Plan or Business Associate terminates the agreement to restrict, then the termination is effective only with respect to information created or received after the date of notice of the termination of the restriction.

- D. The individual understands that if Plan's Business Associate has agreed to a request for restriction, restricted protected health information still may be disclosed to provide emergency treatment, but that Plan/Business Associate will not further use or disclose restricted protected health information for any other purpose.
- E. The individual understands that he/she still has a right to access protected health information as allowed under the Privacy Rule and any other applicable law.
- F. The individual understands that he/she may receive an accounting of certain disclosures of protected health information as explained in the Plan's Notice of Privacy Practices.
- G. The individual understands that restricted protected health information may still be disclosed for public policy purposes as stated in the Notice of Privacy Practices.

INDIVIDUAL SIGNATURE: _____

INDIVIDUAL NAME (Please Print): _____

PLAN BUSINESS ASSOCIATE TO COMPLETE THE FOLLOWING:

The Request for Restriction is: Accepted Denied

*If Request is accepted in part, describe the restriction to be implemented:

Date Restriction Becomes Effective: _____

Signature of Plan Business Associate Representative:

Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I. INDIVIDUAL DATA:

INDIVIDUAL'S NAME: _____

PLAN ID NUMBER: _____

ADDRESS: _____

TELEPHONE NO.: _____

II. NATURE OF REQUESTED RESTRICTION

A. I represent that I *could be endangered* if my Plan fails to communicate my protected health information by an alternative means or at an alternative location. *[Please initial.]* _____

B. I request my Plan or its Business Associate to communicate with me regarding my protected health information in the following alternative manner or method.

At a telephone number other than my home number. The telephone number at which I should be contacted is:

_____.

At a mailing address other than my home mailing address. The mailing address at which I should be contacted is:

_____.

Through my e-mail address, rather than my home address. My e-mail address for purpose of contacting me is:

_____.

Other. Please specify:

_____.

III. CONDITIONS GOVERNING THE REQUEST FOR CONFIDENTIAL COMMUNICATIONS:

Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), a Plan and its Business Associate are required to honor only *reasonable* Requests for Confidential Communications if a disclosure of protected health information could endanger the individual. A Plan/Business Associate may condition granting the request for reasonable accommodation upon the following:

1. The Individual providing information concerning how premiums or other payments will be handled; and
2. The individual specifying an alternative address or other method of contact.

INDIVIDUAL SIGNATURE: _____

INDIVIDUAL NAME (Please Print): _____

PLAN/BUSINESS ASSOCIATE TO COMPLETE THE FOLLOWING:

The Request for Confidential Communications has been reviewed by the Plan/Business Associate and is:

Accepted

Denied (Request cannot reasonably be accommodated)

Date Restriction Becomes Effective: _____ / _____ / _____

Comments: _____

Signature of Plan/Business Associate Representative:

Date: _____