Forms for Use With

FCA HIPAA and Sections 466.057 & 501.171, Florida Statutes,

PRIVACY & SECURITY COMPLIANCE MANUAL 2018

Prepared by:

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Format Note
This document is in Word. Set the font at Times New Roman and the font size at 12 to have page numbers match the Table of Contents. This should be Page 1.

Compliance Checklist

Verify:	Completed:
That the Resolution of Adoption of the Compliance Manual is signed and in the three ring manual binder	
Privacy Notice is posted in waiting room and posted on website (if applicable)	
Privacy Officer and Security Officer (can be combined for one person and referred as HIPAA Compliance Officer) is appointed and understands duties	
That each patient file has a signed, up to date Notice of Privacy Practices and Acknowledgment of Receipt of Notice of Privacy Practices	
That a log of disclosures of patient records to third parties is maintained in patient files	
Each Business Associate has signed a Business Associate Agreement	
Business Associate Agreements are all in one file with a log of all of them	
Computer operators log off when leaving a computer unattended for more than 3 minutes	
Any wireless network used in the Practice is utilized by a Business Class router and the default password has been changed to a string passphrase	
Maintain a log of all passwords used by any physician or employee to access PHI. Periodically change the passwords, at least every 90 days	
Any wireless device that accesses PHI is secure from theft, utilizes encryption if ePHI is stored and remote wipe if ePHI is accessed.	
Software used to access and transmit PHI is up to date, including any encryption software	
The office HIPAA manual is in a safe secure place	
Policies, standards, and procedures to protect the confidentiality and security of the medical records have been adopted and in the three ring manual binder	
Employees have been trained in all the policies, standards, and procedures and that their dates of training are entered into the log	

PRACTICE RESOLUTION
ADOPTION OF HIPAA PRIVACY COMPLIANCE MANUAL

WHEREAS, **The Twisted Spine LLC.** desires to comply with the privacy protection requirements of the HIPAA Privacy Rule, the Security Rule, the HITECH Act, the Omnibus Rule and Florida Statutes 456.057; and

WHEREAS, the Practice has reviewed the Privacy Manual; and

WHEREAS, the Privacy Manual is intended to satisfy fully the requirements of the HIPAA Privacy Rule, the Security Rule, the HITECH Act and Regulation and Florida Statutes 456.057;

NOW THEREFORE, BE IT RESOLVED, that the **The Twisted Spine LLC.** hereby approves of the adoption of this HIPAA Privacy Compliance Manual and all policies therein to protect Protected Health Information, effective **4/3/2019** [insert date], with the expectation that all employees, including those with an ownership interest in this Practice, will be instructed in their respective duties under this Manual and will comply fully therewith.

Date: 4/3/19

By: Amy Wolf D.C MGMR
[Insert name of authorized signer]

APPOINTMENT OF A PRIVACY OFFICER AND CONTACT PERSON

WHEREAS, ___**The Twisted Spine LLC.** , having adopted this HIPAA Privacy/Security Compliance Manual; and

WHEREAS, the Manual requires the appointment of a Privacy Officer and Contact Person; and

NOW THEREFORE, BE IT RESOLVED, that
Amy Wolf D.C. MGMR. is to be the Privacy Officer and Contact Person of this Practice beginning _____4/3/19_____, and continuing until changed in accordance with this HIPAA Privacy/Security Compliance Manual; and

BE IT FURTHER RESOLVED, that the Privacy Officer / Contact Person will vigorously carry out the duties set forth in this Manual and that all employees of this Practice will be informed of the importance of adherence to this HIPAA Privacy/Security Compliance Manual and the importance of their cooperation with the Privacy Officer/Contact Person.

Date:_____4/3/19_____

By:_____Amy Wolf D.C. MGMR_____
[insert name of owner of the Practice or the person authorized to act on behalf of the Practice]

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
and
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES
forms.

{ The Twisted Spine LLC }
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
(45 CFR 164.520)

PLEASE REVIEW THIS NOTICE CAREFULLY.

This notice describes how medical information about you may be used and disclosed and you can get access to that information as required by 45 CFR 164.520.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. This Notice may be amended or revised at which time you will be provided the revised or amended Notice to review.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

- (a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

- (b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

- (c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) Any information is deleted that would identify you.

(b) To a company or person who is not employed by the practice to provide a service such as billing insurance and/or electronic records. These persons/companies are called "Business Associates." Only that information necessary to perform the service will be submitted to the business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

(c) To a person that you designate as a personal representative who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Appointment reminders are used by the Practice. The Practice will use those methods which you designate at the end of this Notice, such as: a) a postcard mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone; or sending you an email or text message.

DIRECTORY/SIGN-IN LOG

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request

(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Receive notice of any breach of confidentiality of your PHI by the Practice.

(i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

(j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850 414-3300 if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(k) Request copies of your PHI in electronic format.

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Amy Wolf D. C. MGMR, at 386-202-2272 or via email at drwolfdc@gmail.com.

PRACTICE'S REQUIREMENTS

1. The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:

  Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted diseases, Section 456.057 relating to patient records ownership, control and disclosure and Section 501.171 relating to protecting your personal information, Social Security and driver license numbers, credit or debit card information, financial accounts information, email address, and medical information.

- (c) Is required to abide by the terms of this Privacy Notice.

- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

- (e) Will distribute any revised Privacy Notice to you prior to implementation.

- (f) Will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below whom is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer is ___Amy Wolf D.C MGMR_____.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE

This Notice is in effect as of _04__/_03__/2019___.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail _____;
Email_____; at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail _____;
Email _____ at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____	_____
_____	_____
_____	_____

Notice of
ELECTRONIC TRANSFER OF PROTECTED PATIENT INFORMATION
PRIVACY PRACTICE

Following is a notice of electronic transfer of protected patient information privacy practice followed by the practice. It should be posted in a prominent place in the patient waiting room, any practice website or social media pages.

ELECTRONIC TRANSFER OF PROTECTED PATIENT INFORMATION PRIVACY PRACTICE

The **The Twisted Spine LLC** _____ seeks to protect the privacy of Protected Health Information stored on computers of the **The Twisted Spine LLC** __ or transmitted via the internet.

Only authorized employees shall have access to computers on which Protected Patient Information is stored. All computers will be protected with a password. Only authorized employees may use a password to access computers. The password will be periodically changed and changed any time an authorized employee leaves the Practice's employ.

Only the owners of the practice will be authorized to take out of the Practice's premises back up discs or flash drives onto which Protected Patient Information has been copied. The owner will take appropriate steps to protect the information on the discs or flash drives from unauthorized disclosure. Back up data will be stored in a secure place.

Any electronic claims that may be filed using software that is approved for electronic transmissions of Protected Health Information and which protects the privacy of such information as it becomes available.

The Practice will make certain that any billing services used by the Practice to electronically file claims on behalf of the Practice have a policy adopted that protects Protected Health Information and that uses software that is approved for electronic transmissions of Protected Health Information and which protects the privacy of such information.

HIPAA Compliant Authorization for Release of Patient Information Form

Print the form on the following two pages and fill in the name of the practice where appropriate and have patient sign the form when needed.

HIPAA Compliant Authorization for Release of Patient Information
Pursuant to 45 CFR 164.508

Section I – Patient Information
Name:
Relationship to patient:
Street address:
City, State & Zip Code:
Telephone:
Email address:

Section II: Authorization for Release of Patient Information: I, or my authorized representative, hereby authorize _____(name of entity holding the requested records) and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to: _____(name, address & telephone number of chiropractic practice).

Section III – Specific Information to be Released:
☐ Please release my Medical Record from (insert date) _____ to (insert date) _____.
☐ Please release my entire Medical Record, including patient histories, office notes (excluding psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records sent (insert name of practice) by health care providers.
☐ Other: (please explain) _____
_____
_____

Reason for release of information:
☐ Include: (Indicate by Initialing) _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information
☐ At the request of the individual
☐ Other:
_____

Section I – Patient Information
Name:
Relationship to patient:
Street address:
City, State & Zip Code:
Telephone:
Email address:

Section IV: I understand that Section 460.413 (1) (m), Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:
Date or event on which this authorization will expire: _____.
If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE
By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

_____ _____
Signature of Member or Authorized Representative Date

Name:
Relationship to patient:
Street address:
City, State & Zip Code:
Telephone: Email address:

Prepared by Paul Watson Lambert, General Counsel, Florida Chiropractic Association

LOG OF PATIENT INFORMATION DISCLOSURES FORM

Upon furnishing patient information to any third party the name of the third party to whom the information is furnished is required to be listed in the following form, including the date furnished, the method of furnishing the information and a brief description of the information furnished. The log must be maintained in the patient's medical records file.

LOG OF PATIENT INFORMATION DISCLOSURES

Pursuant to a **HIPAA Compliant Authorization for Release of Patient Information Form** signed by the patient on _____ the following information about patient's medical condition was furnished to:

Name of person to whom the information was furnished.

Date that the information was furnished.

Method of delivery of the information.

Brief description of the information furnished.

ACCOUNTING OF DISCLOSURES FORM

The following form is to be completed and submitted to a patient requesting an accounting of all releases of the patient's medical information.

ACCOUNTING OF DISCLOSURES FORM

There is recorded on these form any and all disclosures of information contained in the medical record to any third party, including the purpose of the disclosure, required to be maintained by Florida Statute 456.057 (12) and provided to a patient upon request pursuant to HIPAA regulations. This form shall be maintained as part of the patients' records pursuant to Florida Statute 456.057 (12). A copy of this form shall be provided to any patient requesting an accounting or a copy of their patient records. This form will be maintained as part of the medical records for at least six years.

_____

Signature of Privacy Officer Date Provided to Patient

DATE OF DISCLOSURE	PERSON / ENTITY TO WHOM DISCLOSURES WERE MADE	RECORD OF INFORMATION DISCLOSED	REASON FOR DISCLOSURE
_____	_____	_____	_____

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED PATIENT INFORMATION

I hereby request an accounting all disclosures of my patient protected information.

_____ _____

Patient's or Patient's Legal Representative's Signature Patient's Date of Birth

_____

Date Request is signed

REQUEST FOR CORRECTION OR AMENDMENT OF HEALTH INFORMATION FORM

The following form is to be used whenever a patient requests a correction or amendment of health information in the patient's records.

REQUEST FOR CORRECTION OR AMENDMENT OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient's Address: _____

_____

Patient's Phone Number: _____

Date of Entry to be Amended: _____

Type of Entry to be Amended: _____

Statement as to why the entry is incorrect or incomplete and what the entry should state to be more complete or accurate.

_____

_____

Please list those people to whom we have sent the erroneous information and whom you would like to have a copy of the amended information sent:

Name: _____

Address: _____

Name: _____

Address: _____

_____ _____
Patient's or Patient's Legal Representative's Signature Date

For use by the Privacy Officer

Date received _____ Amendment ____ Accepted ____ Denied

Reason for denial:

____ PHI was not created by the Practice
____ PHI is not part of patient' designated record set
____ PHI is accurate and complete

Additional comments:

Signature of Privacy Officer:_____ Date: _____

Signature of Physician: _____ Date: _____

PATIENT COMPLAINT FORM

This form is to be given to a patient wishes to make a complaint regarding the Practice's privacy policies, procedures and practices or failure to protect a patient's Protected Health Information. The completed form is to be submitted to the Privacy Officer.

PATIENT COMPLAINT FORM

Patient Name: _____ Patient's Birth Date: _____

Name of Person Submitting Complaint If Other Than Patient:

_____

Relationship to Patient: _____

Date of Occurrence: _____

Name of Practice Employee Involved in Matter: _____

Description of occurrence and reason for complaint:

_____

_____

_____

Describe the action you want this office to take relating to this occurrence:

_____

_____

_____

Signature DATE

FOR USE BY PRACTICE OFFICER ONLY

Description of action taken to address complaint:

_____

_____

Signature of Privacy Officer:

_____

Date: _____

REQUEST FOR SPECIAL CONFIDENTIAL COMMUNICATIONS PROCEDURES

I hereby request that _____ (name of practice) request that all written communications to be mailed only to the following address:

I hereby request that _____ (name of practice) request that all telephone calls placed to me only be placed to: _____.

I hereby request that _____ (name of practice) request that no voice mail messages be left on the above listed or any other telephone listings relating to me.

_____ _____

Patient's Signature Patient's Date of Birth

For Use by Privacy Officer Only

Practice:____ Accepts_____ Denies

Signature of Privacy Officer: _____

Date: _____

HIPAA BUSINESS ASSOCIATE AGREEMENT FORM

A Business Associate is someone who is not an employee of the Practice who has access to PHI. A Business Associate Agreement (BAA) is an agreement by which a Business Associate agrees to keep confidential any PHI to which the Business Associate is exposed. Following is a BAA form.

HIPAA BUSINESS ASSOCIATE AGREEMENT

COMPLIANT WITH HITECH ACT OF 2009

This is an agreement between _____(name of business associate) referred to as "Business Associate" and _____(name of the practice) referred to as "Covered Entity."

Definitions

Terms used, but not otherwise defined in this Agreement shall have the same meaning as those terms in the Privacy Rule.

Examples of specific definitions:

a. **HIPAA Rules.** "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

b. **Breach of HIPAA and HiTech Act**. Section 13400(1) of the HiTech Act defines ''breach'' to mean, generally, the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information.

c. **Business Associate.** "Business Associate" shall mean (name of contractor)

d. **Covered Entity.** "Covered Entity" shall mean (name of practice) .

e. **Disclosure of Breach.** Section 13402(b) of the Act requires a business associate of a covered entity that accesses, maintains, retains, modifies, records, destroys, or otherwise holds, uses, or discloses unsecured protected health information to notify the covered entity when it discovers a breach of such information, so that the covered entity can notify affected patients.

f. **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).

g. **HITECH Act of 2009** means Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) that was enacted on February 17, 2009.

h. **Law Enforcement official.** "Law enforcement official" means an officer or employee of any agency or authority of the United

States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

(1) Investigate or conduct an official inquiry into a potential violation of law; or

(2) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

b. **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.

c. **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 Covered Entity.

d. **Required By Law.** "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

e. **Secretary.** "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

f. **Unsecured Protected Health Information.** Section 13402(h) of the HITECH Act defines ''unsecured protected health information'' as ''protected health information that is not secured through the use of a technology or methodology.

Obligations and Activities of Business Associate

1. Business Associate agrees not to use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.

2. Business Associate agrees to maintain all computers on which patient protected information is stored in a secure manner in compliance with Subpart C of 45 CFR Part 164 protected from access by anyone who is not entitled to access the Protected Health Information.

3. Business Associate agrees to transmit electronically Protected Health Information only in a secure manner by encryption or other secure manner.

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

5. 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 Agreement.

6. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

7. 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 Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

8. Business Associate agrees to provide access, at the request of Covered Entity to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.

9. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual.

10. 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, Covered Entity available to Covered Entity, for purposes of the Secretary determining Covered Entity compliance with the Privacy Rule. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered 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.

11. Business Associate agrees to provide to Covered Entity or an Individual, information collected in accordance with this Agreement, to permit Covered 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.

12. Business Associate has appointed _____ as their HIPAA Security Officer as a point of contact.

Permitted Uses and Disclosures by Business Associate

General Use and Disclosure Provision

Purpose:

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information on behalf of Covered Entity for the following purposes, provided that such use or disclosure of Protected Health Information would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity: To provide information to law enforcement officials and to petition such officials for related investigations.

Obligations of Covered Entity

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity 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.

b. Covered 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 use or disclosure of Protected Health Information.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered 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.

Permissible Requests by Covered Entity

Covered 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 Covered Entity.

Term and Termination

a. **Term.** The Term of this Agreement shall be effective as of _____, 20__, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered 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.

b. **Termination for Cause.** Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

    1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

    2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

    3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

c. **Effect of Termination.**

    1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created

or received by Business Associate on behalf of Covered 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.

2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon notification that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes.
3. Return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Miscellaneous

a. **Regulatory References.** A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

b. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered 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.

c. **Survival.** The respective rights and obligations of Business Associate of this Agreement shall survive the termination of this Agreement.

d. **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

Contractor

_____ _____

By (person signing for contractor) Date

_____

(Name of chiropractic practice.)

_____ _____

By Dr. Date

Prepared by Paul Watson Lambert, General Counsel, Florida Chiropractic Association

This Business Associate Agreement is intended for use only by members of the Florida Chiropractic Association.

Log of Business Associate Agreements Form

Following is a form on which to log all business associate agreements entered into. The log must be maintained as part of the HIPAA compliance manual.

Log of Business Associate Agreements

Name of Business	Date	Reason for Access to PHI	Expected Frequency of Access to PHI	Associate Signed

PRIVACY TRAINING AND EDUCATION LOG FORM

Following is a form to log training of employees on protection of patient protected information as set forth in the *FCA HIPAA & SECTIONS 466.057 & 501.171, FLORIDA STATUTES, PRIVACY & SECURITY COMPLIANCE MANUAL 2016*.

PRIVACY TRAINING AND EDUCATION LOG

Date of Training	Name of Employee	Description of Training	Training Hours	Person or Company Providing Training

NOTICE TO INDIVIDUAL PATIENT OF BREACH OF PROTECTED PATIENT INFORMATION FOR BREACH OF FEWER THAN 10 PATIENTS FORM

Following is a form to notify patients of a breach of their patient information confidentiality when the breach affects fewer than 10 patients.

NOTICE TO INDIVIDUAL PATIENT OF BREACH OF PROTECTED PATIENT INFORMATION FOR BREACH OF FEWER THAN 10 PATIENTS

Send by U.S. Postal Service or other delivery service or email, if the patient has elected to receive information by email, the notice below. In the event that the contact information out-of-date for one or more of the ten patients post the notice on the practice's web page for 90 days. A personal representative or next of kin should be contacted in the instance the patient is deceased.

NOTICE OF BREACH OF YOUR PROTECTED PATIENT INFORMATION

(Name of practice) discovered on (date) that the confidentiality of your Protected Patient Information was breached. (State the suspected date of the breach or that the date of the breach is unknown. Describe the types of unsecured PHI that were involved in the breach, whether the full name, home address, Social Security number, date of birth, account number, diagnosis, disability code, or other types of information were involved.)

(Describe: 1) any steps individuals should take to protect themselves from harm resulting from the breach; 2) a brief description of what the practice is doing to investigate the breach, mitigate harm to individuals and protect against any further breaches; 3) contact procedures for individuals to ask questions or learn additional information, including a telephone number, an email address, web site or postal address.

NOTICE TO THE MEDIA OF BREACH OF MORE THAN 500 PATIENTS OF PHI

In the event that PHI of greater than 500 patients, the practice shall post the notice form below on the practice's web site and submit the notice to the local media without reasonable delay and no later than 60 days following discovery of the breach.

NOTICE OF BREACH OF PROTECTED PATIENT INFORMATION

(Name of practice) discovered on (date) that the confidentiality of Protected Patient Information of greater than 500 patients was breached. (State the suspected date of the breach or that the date of the breach is unknown. Describe the types of unsecured PHI that were involved in the breach, whether the full name, home address, Social Security number, date of birth, account number, diagnosis, disability code, or other types of information were involved.)

(Describe: 1. any steps individuals should take to protect themselves from harm resulting from the breach; 2. a brief description of what the practice is doing to investigate the breach, mitigate harm to individuals and protect against any further breaches; 3. contact procedures for individuals to ask questions or learn additional information, including a telephone number, an email address, web site or postal address.

NOTICE TO THE SECRETARY OF HHS OF BREACH OF PHI OF MORE THAN 500 PATIENTS FORM

Following is a form to notify the Secretary of the U.S. Department of Health and Human Services in the event that the PHI of greater than 500 patients has been breached.

NOTICE TO THE SECRETARY OF HHS OF BREACH OF PHI OF MORE THAN 500 PATIENTS

The practice is required to notify the Secretary of the U.S. Department of Health and Human Services in the event that the PHI of greater than 500 patients has been breached. Below is a suggested wording of a letter notifying the Secretary.

Secretary's Name
Hubert Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear (Madam or Mister) Secretary:

(Name of practice) discovered on (date) that the confidentiality of Protected Patient Information of greater than 500 patients was breached. (State the suspected date of the breach or that the date of the breach is unknown. Describe the types of unsecured PHI that were involved in the breach, whether the full name, home address, Social Security number, date of birth, account number, diagnosis, disability code, or other types of information were involved.)

(Describe: 1) any steps individuals should take to protect themselves from harm resulting from the breach; 2) a brief description of what the practice is doing to investigate the breach, mitigate harm to individuals and protect against any further breaches; 3) contact procedures for individuals to ask questions or learn additional information, including a telephone number, an email address, web site or postal address.

NOTICE TO THE SECRETARY OF HHS OF BREACH OF FEWER THAN 500 PATIENTS OF PHI

The practice is required to maintain a log of breaches of PHI involving fewer than 500 patients. The practice is required to submit the log to the Secretary of the U.S. Department of Health and Human Services no later than 60 days after the end of the calendar year in which the breaches were discovered. Below is a suggested wording of a log notifying the Secretary.

LOG OF BREACHES OF PHI DURING THE CALENDAR YEAR OF 20XX

Date of Discovery	Date of Breach (If known)	Action Taken	Number of Patients	Date Patients Notified

Mail the log to the Secretary at the address above.

Security of Confidential Personal Information Act Form

Following is a form to be completed after it is determined that access of breached personal information has not and will or will not likely result in identity theft or any other financial harm to the patients whose personal information has been accessed.

Security of Confidential Personal Information Act

Determination that access of personal information has not and will or will not likely result in identity theft or any other financial harm to the patients whose personal information has been accessed.

On _____(date) it was learned that unauthorized persons accessed personal information of more than 500 patients. The personal information was accessed by _____(describe the method of access). The access was reported to the _____(law enforcement agency) on _____(date). It was determined that access of personal information has not and will or will not likely result in identity theft or any other financial harm to the patients, because _____(explain the reason).

Furnished to the Office of Attorney General, State of Florida, The Capitol PL-01, Tallahassee, FL 32399-1050 by mail on _____(date).

_____(Name and address of practice.)

Notice to the Department of Legal Affairs of Breach of Security of Personal Information of More than 500 Patients Form

Following is a form to notify the Florida Attorney General of a breach of patient personal information of more than 500 patients.

Security of Confidential Personal Information Act

Notice to the Department of Legal Affairs of Breach of Security of Personal Information of More than 500 Patients

Office of Attorney General
State of Florida
The Capitol PL-01
Tallahassee, FL 32399-1050

On _____(date) it was learned that unauthorized persons accessed personal information of more than 500 patients. The personal information was accessed by _____(describe the method of access). The access was reported to the _____(law enforcement agency) on _____(date). The method of access was _____(describe). The personal information accessed is _____(describe). The number of patients affected numbers _____.

The practice is assisting the affected patients by _____(describe).

The following person at the practice may be contacted for further information: _____(name, address email address and telephone number).

Enclosed is a copy of the notice furnished to affected patients, a police report, incident report, or computer forensics report and a copy of the policies in place regarding breaches.

The following steps have been taken to rectify the breach: _____.

_____Signature of chiropractic physician and address.

Security of Confidential Personal Information Act

Notice to Patients of Breach of Security of Personal Information of More than 500 Patients

On _____(date) it was learned that unauthorized persons accessed personal information of more than 500 patients. The personal information was accessed by _____(describe the method of access). The access was reported to the _____(law enforcement agency) on _____(date). The method of access was _____(describe). The personal information accessed is _____(describe). The number of patients affected numbers _____.

The practice is assisting the affected patients by _____(describe).
The following person at the practice may be contacted for further information: _____(name, address email address and telephone number).

The following steps have been taken to rectify the breach: _____.

_____ (Signature of chiropractic physician and address.)

Notice to the Credit Reporting Agencies of Breach of Security of Personal Information of More than 500 Patients Form

Following is a form notifying the credit reporting agencies of a breach of personal information of more than 1,000 patients.

Security of Confidential Personal Information Act

Notice to the Credit Reporting Agencies of Breach of Security of Personal Information of More than 500 Patients

To: Experian, TransUnion and Equifax

On _____(date) it was learned that unauthorized persons accessed personal information of more than 500 patients. The personal information was accessed by _____(describe the method of access). The access was reported to the _____(law enforcement agency) on _____(date). The method of access was _____(describe). The personal information accessed is _____(describe). The number of patients affected numbers _____.

The following person at the practice may be contacted for further information: _____(name, address email address and telephone number).

Enclosed is a copy of the notice furnished to affected patients, a police report, incident report, or computer forensics.

_____Signature of chiropractic physician and address.