

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____, do hereby
acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

Signature of Individual

Date

In the event this request is made by the individual's personal representative:

Signature of Personal Representative

Date

Legal Authority of Personal Representative

**“GOOD FAITH EFFORT” TO GAIN ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

This is an acknowledgment of a good faith effort, in regards to the following client:

Client Name _____ **ID#** _____

A copy of the Notice of Privacy Practices has not been given to the individual for the reason(s) stated below:

Employee Signature

Date

Certified Mail Return Receipt Attached

ACCOUNTING OF DISCLOSURES

Individual's Name _____

Individual's Social Security Number _____

Date Request Received	Person Making Request	Date of Disclosure	Name and Address of Recipient of PHI	Description of PHI Disclosed	Purpose of Disclosure (or copy of written request)	Name of Staff Processing Request

**INDIVIDUAL REQUEST FOR
PROTECTED HEALTH INFORMATION**

This form constitutes an individual's request for protected health information (PHI) held by Cerro Gordo County. To obtain your PHI, this form must be filled out in its entirety.

Name (First/Middle/Last) _____

Address (Street/City/State/Zip code) _____

Date of Birth (Month/Day/Year) _____

Social Security Number _____ Date of Request _____

I request Cerro Gordo to provide me access to the following PHI about me:

- Mental Health Records
- Medical Records
- Billing Records
- Other _____

I request access to my PHI for the dates covering the following time period(s):

From: (Month/Day/Year) _____ To: (Month/Day/Year) _____

I would like to obtain the requested PHI in the following format:

- Electronic sent to the following address _____
- Hardcopy sent to the following address _____
- Other: _____
- On-site inspection

I understand Cerro Gordo County may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with my request.

Signature of Individual

Date

In the event this request is made by the individual's personal representative:

Signature of Personal Representative

Date

Legal Authority of the Personal Representative

**NOTICE OF DECISION
REGARDING INDIVIDUAL REQUEST FOR
PROTECTED HEALTH INFORMATION**

Your request to access the following protected health information (PHI):

- Medical Records
 Billing Records
 Other _____

For PHI, covering the dates of: ____/____/____ through ____/____/____

In the following format:

- Copies of requested information (Cost: \$_____)
 Inspection of my health information at Cerro Gordo County.

Has been:

Accepted

Denied

Reason for Denial:

- You do not have a right to access the information, nor to request a review of this decision, as it falls under the following category:
- Psychotherapy notes;
 - PHI requested is related to civil, criminal, or administrative action;
 - PHI requested is subject to, or exempt from, the Clinical Laboratory Improvements Amendments of 1988 (CLIA);
 - You are an inmate, and the PHI requested could jeopardize the health, safety, security, custody, or rehabilitation of yourself or others;
 - You have agreed to participate in research and have been notified that this information is restricted while in course of the research. You may access the information upon completion of the research;
 - The PHI requested is subject to the Privacy Act;
 - The PHI requested was obtained from a third party (non-health care provider) under condition of confidentiality.
- Your request has been denied for the following reason (*Note: You may request a review of this decision by following the appeal procedure outlined on the back of this decision.*):
- A licensed Health Care Professional has determined that the access requested is likely to endanger the life or physical safety of yourself or others;
 - The PHI requested makes reference to someone else and is likely to cause that person serious harm;
 - As a personal representative, it is believed that access to the requested PHI may subject the individual you represent to domestic violence, abuse, or neglect; or may endanger their life; or is not in the best interest of the individual represented.
- Other: _____

April 14, 2003
CERRO GORDO COUNTY

Staff Signature: _____ Date: _____

Date Request Received: _____

Request for Reviews:

You may have this decision reviewed by sending a written request to: Mary Beth Nelson, Privacy Officer, Cerro Gordo County, 220 North Washington Avenue, Mason City, IA 50401. 641-421-3122. The request must be received within 7 days from the above date. The review process is described on the reverse.

REVIEW PROCEDURE

The purpose of this section is to describe how Cerro Gordo County decisions can be reviewed.

- If you disagree with this notice of decision, you may seek a review of the decision. Only reviews initiated by you or your personal representative will be evaluated.
- To request a review, you must send a written notice requesting a review within ten (10) working days of receipt of your Notice of Decision. Send your request to: Mary Beth Nelson, Privacy Officer, Cerro Gordo County, 220 North Washington Avenue, Mason City, Iowa 50401.
- Within five (5) working days of the receipt of the written request for a review, Cerro Gordo County shall send you a written notice informing you of the date, time, and place that the review will be conducted.
- A written decision will be issued no later than ten (10) working days after the review proceeding. A copy of that decision will be sent to you and your representative (if applicable). A notice explaining the effect of the decision, regarding access to your private health information and your rights regarding any subsequent review, will accompany the decision.
- The review proceeding shall be held privately. At any review, you have the right to be present and have an attorney or other advocate accompany and represent you, at your own expense. If you cannot afford an attorney, you may contact Legal Services Corporation of Iowa, the Iowa Volunteer Lawyer Project, or Iowa Protection and Advocacy Services, Inc., for assistance.

REQUEST FOR ACCOUNTING OF DISCLOSURES

Name: (First/ Middle/ Last) _____

Address: (Street/ City/ State/ Zip code) _____

Date of Birth: (Month/ Day/ Year) _____ Social Security Number: _____

Date of Request: _____

I request an accounting of all disclosures for the following time period: *(Note: The maximum time period that can be requested is six years prior to the date of your request but not for time periods prior to April 14, 2003.)*

From: (Month/ Day/ Year) _____ To: (Month/ Day/ Year) _____

I request the accounting be sent to the following address:

I understand that there is no charge for the first accounting request in a 12-month period. For subsequent requests in the same 12-month period, the charge is \$_____.

I understand the following: *(Check one.)*

_____ There is no fee for this request.

_____ There is a fee for this request.

I understand the accounting I have requested will be provided to me within 60 days of this request, unless I am notified in writing that an extension of up to 30 days is needed.

Signature of Individual

Date

In the event this request is made by the individual's personal representative:

Signature of Personal Representative

Date

Legal Authority of the Personal Representative

For Cerro Gordo County Use:

Date request received: _____ Date accounting sent: _____

Extension requested: _____ No _____ Yes – Reason _____

_____ Individual notified in writing of extension

Name of individual processing request: _____

**INDIVIDUAL'S REQUEST FOR AMENDMENT
OF PROTECTED HEALTH INFORMATION**

Name: (First/ Middle/ Last) _____

Address: (Street/ City/ State/ Zip code) _____

Date of Birth:(Month/ Day/ Year)_____ Social Security Number: _____

Date of Request: _____

Date of entry to be amended: _____

Type of entry to be amended: _____

Please explain how the entry is incorrect or incomplete. What should the entry say, to be more accurate or complete?

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

I understand that Cerro Gordo County reserves the right to amend the protected health information, based on my request; and the original entry(ies) in the record will not be altered. This request to amend will be made a part of my permanent health care record.

Signature of Individual

Date

In the even this request is made by the individual's personal representative:

Signature of Personal Representative

Date

Legal Authority of Personal Representative

For Cerro Gordo County Use:

Date received: _____ Accepted _____ Denied _____

If denied, check reason for denial:

_____ PHI is accurate and complete.

_____ PHI was not created at this organization.

_____ PHI is not part of individual's designated record set.

_____ Pursuant to federal law, PHI is not available to individual for inspection (e.g. psychotherapy notes)

_____ If denied, individual was informed of denial in writing.

_____ If accepted, individual was informed of acceptance.

Name/ Title of individual processing this request: _____

**REQUEST FOR ALTERNATIVE MEANS OR LOCATION
OF CONFIDENTIAL COMMUNICATIONS**

Name: (First/ Middle/ Last) _____

Address: (Street/ City/ State/ Zip code) _____

Date of Birth: (Month/ Day/ Year) _____ Social Security Number: _____

Date of Request: _____

I request Cerro Gordo County to communicate confidential information to me in the following manner:

Telephone communication at the following telephone number: _____
_____ Leave a message on an answering machine at this number.
_____ Do not leave a message on an answering machine at this number.

Written communication is to be mailed to the following address:

Other: _____

I further understand that Cerro Gordo County may condition its acceptance of these conditions upon how payment for services will be made or upon my providing an alternate address or other method of contact.

Signature of Individual Date

In the event this request is made by the individual's personal representative:

Signature of Personal Representative Date

Legal Authority of Personal Representative

For Cerro Gordo County Use:

_____ Accept request for alternative communication.

_____ Reject request for alternative communication. Reason rejected: _____

Name/ Title of individual processing this request: _____

Date request processed: _____

CONFIDENTIAL REPORT OF CONCERN

The purpose of this form is to report the facts pertaining to any known or suspected violation of Cerro Gordo County's privacy standards or the laws and regulations governing Cerro Gordo County. Although we ask you to provide your name, it is not necessary for you to do so if you wish to make an anonymous report. An anonymous report can be made by completing this form and mailing it to the Privacy Officer at Cerro Gordo County. If you do not want to give your name, you may call the Privacy Officer within one week of submitting this report to inquire about the outcome of the investigation.

If you wish to identify yourself in this report, Cerro Gordo County will make every effort to keep your identity confidential, unless you give Cerro Gordo County permission to reveal it. Only the Privacy Officer, and others designated by the Privacy Officer, will have access to your report. No disciplinary action or retaliation will be taken against you for making a good faith report of a compliance violation.

Please include all the factual details of the suspected violation, however big or small, to ensure that the Privacy Officer has all of the information necessary to conduct a thorough investigation. Please attach additional pages, as needed. The information that you provide should include names, dates, times, places, and a detailed description of the incident that led you to believe that a violation of Cerro Gordo County's privacy standards occurred. Please include a copy or description of any documents that support your concerns.

Date of this report: _____

Name of person making this report (optional): _____

Description of the violation(s): _____

Detailed description of the incident(s) resulting in the violation(s) (include names, dates, times, and places): _____

Name(s) of person(s) involved in the incident and an explanation of their role(s): _____

Name(s) of other person(s) having knowledge of the incident: _____

Department where the incident occurred: _____

Date(s) of the incident: _____

Explanation of how you became aware of the suspected violation: _____

Please attach or describe any documents that support your concern (include a description of the documents, the identity of the persons who wrote the documents, the dates of the documents, and the location of the documents): _____

EMPLOYEE CONFIDENTIALITY AGREEMENT

I, the undersigned, have read and understand Cerro Gordo County's policy on the "Workforce Confidentiality Policy." In consideration of my employment or association with Cerro Gordo County, and as an integral part of the terms and conditions of my employment or association, I hereby agree that I will not, at any time, during my employment or after my employment or association ends, access or use protected health information, or reveal or disclose to any persons within or outside Cerro Gordo County, any protected health information, except as may be required in the course of my duties and responsibilities and in accordance with applicable local, state, or federal laws governing proper release of information.

I also understand that unauthorized use or disclosure of protected health information will result in disciplinary action, up to and including termination of employment or association, and the possible imposition of fines, pursuant to applicable state and federal laws.

Date

Employee Signature

Department

I have discussed the Workforce Confidentiality Policy, and the consequences of a breach, with the above named.

Signature of individual administering agreement

Date

April 14, 2003
CERRO GORDO COUNTY

COMPLIANCE REPORT INVESTIGATION FORM

Date of reported concern: _____

Name of person who received the report: _____

Name of person who made the report (state "unknown" if the report was made anonymously):

Date(s) of investigation: _____

Name(s) of person(s) investigating: _____

Name(s) of person(s) interviewed: _____

Description of documents reviewed: _____

Findings: _____

Plan of correction: _____

Signature of Privacy Officer

April 14, 2003
CERRO GORDO COUNTY

**AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Please complete this form in its entirety. This authorization is not valid, and Cerro Gordo County will not release your protected health information, unless the form is complete in its entirety. A copy of the signed authorization will be provided to you.

The following person(s) or entity shall:

Name(s) of Person(s) or Entity: _____

Address of Person(s) or Entity: _____

To disclose the following information from the health records of:

Name: (First/ Middle/ Last)_____

Address: (Street/ City/ State/ Zip code)_____

Birth Date: (Month/ Day/ Year)_____ Social Security #:_____

Telephone Number: (Home)_____ (Work)_____

This information shall be disclosed to the following person or entity:

Name(s) of Person(s) or Entity: _____

Address of Person(s) or Entity: _____

The information disclosed shall cover health care for the following period(s) of time:

From: (Month/ Date/ Year)_____ To: (Month/ Date/ Year)_____

From: Month/ Date/ Year)_____ To: (Month/ Date/ Year)_____

The information shall be disclosed for the following purposes:

(Not required if the disclosure is requested by the individual.)

The following information shall be released: _____

I understand that this will include information relating to: (Initial, if applicable.)

_____ Acquired Immunodeficiency Syndrome (AIDS) and/ or Human Immunodeficiency Virus (HIV).

_____ Behavioral health service/ psychiatric care.

_____ Treatment for alcohol and/ or drug abuse.

Affirmation of Authorization:

I give the person(s) or entity named above permission to disclose only the information I have identified on this authorization form, to the person(s) or entity I have named, and only for the purposes I have identified. I understand: *(Please initial after reading each statement.)*

_____ This authorization is valid for one year from the date I sign, unless revoked prior to that date.

_____ I may refuse to sign this authorization. (A refusal to sign the authorization may affect payment for, or eligibility for, benefits.)

_____ I may revoke this authorization, in writing, at any time. (A revocation of this authorization may affect payment for, or eligibility for, benefits.) This authorization cannot be revoked, to the extent that Cerro Gordo County has taken action in reliance on the authorization, or the authorization was a condition of obtaining insurance coverage.

_____ This information may be re-disclosed by the person(s) or entity receiving the information and no longer protected by 45 C.F.R., §164.508.

_____ I may access my protected health information by following the procedure outlined in the Notice of Privacy Practices.

Signature of the Individual

Date

In the event this request is made by the individual's personal representative

Signature of personal representative

Date

Legal authority of personal representative

April 14, 2003
CERRO GORDO COUNTY