Williamsburg Township Emergency Services Records Manual

POLICY & PROCEDURE FOR HANDLING RECORDS REQUESTS, BOTH HEALTH INFORMATION AND NON-MEDICAL RECORDS REQUESTS

EFFECTIVE DATE: September 1, 2013

Name of Privacy Officer
915 West Main St Williamsburg, Ohio 45176
513-724-7744

PREFACE

Recognizing our obligation to our clients and the community at large to provide access to records in accordance with State and Federal dictates, as well as to safeguard the privacy rights of our citizens, this department adopts the following manual. The department's privacy officer is charged with keeping the manual up-to-date, as the laws and regulations pertaining to EMS records are likely to change in the future.

This manual has been prepared to assist in our department's compliance with the Ohio Open Records Law (Ohio Rev. Code Sec. 149.43); with the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 1996, as amended; and with the Health Information Technology for Economic and Clinical Health (HITECH) Act passed as a part of the American Recovery and Reinvestment Act of 2009.

We believe the manual is current through the regulations promulgated in January, 2013, by the U.S. Department of Health and Human Services (HHS) for Civil Rights, effective March 26, 2013, and requiring compliance by covered entities such as our department and by our business associates by September 23, 2013.

TABLE OF CONTENTS

Williamsburg Township Emergency Services

EMS INCIDENT REPORT REQUEST INSTRUCTIONS

Note: Emergency incident reports (general dispatch reports, only), are provided to all members of the public. However, EMS reports are considered confidential medical records and are protected by HIPAA and privacy laws. With a valid HIPAA authorization form signed by the patient, these reports will be provided to the patient, or a party the patient has identified in the authorization form.

REQUESTS: All incident report requests should be submitted on the attached Request for Incident Report Form. All requests without the required information will be returned to the requestor. If you do not have the necessary incident information, you may contact us at (513) _____.

Emergency Medical Service (EMS) Reports

- EMS reports are considered confidential medical records, and are protected by privacy laws.
- A patient has a right to a copy of his or her EMS report. The request must be in writing and signed by the patient. A copy of photo identification 9drivers license) must accompany and be attached to the request prior to release of the report.
- Most third party requests require either a HIPPA authorization signed by the patient or a court order. However, there are certain exceptions to these requirements including, but not limited to, requests from: the patient's health care decision maker, another healthcare provider currently treating the patient, or a grand jury subpoena.
- A report for a deceased individual may be given by the EMS to the personal representative of the estate upon presentation of the death certificate and court order showing the appointment of the personal representative.
- A report may be released to a healthcare decision maker (or an individual who is authorized to make health care treatment decisions for the patient, including the parent of a minor or an agent pursuant to a healthcare power of attorney).
- Subpoenas from the Prosecutor's Office do not require a HIPAA authorization signed by the patient.
- The EMS report request must be submitted in person to (Name and Address of EMS) unless the request is made by another health care provider, government agency, private accreditation agency, business associate or by court order or subpoena).
- The individual making a report request must provide photo identification.
- The guardian of a minor making a report request must provide proof of legal guardianship.

REQUEST FORM FOR EMS INCIDENT REPORT

PLEASE COMPLETE THIS FORM IN FULL.

- *If the requestor is a court-appointed personal representative of a deceased patient, the requestor MUST include a copy of the death certificate and court order showing the appointment as a personal representative.*
- *If the requestor is a legal guardian of a minor, the requestor must provide proof of legal guardianship (and photo identification).*

The information requested below must be completed in full. Requests without the required information will be returned to sender. If you do not have the necessary incident information, you may contact the EMS at (513) _____,

REQUESTOR NAME: _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ EMAIL: _____

Date of Incident: _____ Time of Incident: _____

Incident Address: _____

Type of Incident: _____

EMS Incident Report & HIPAA Authorization Forms

A HIPAA Authorization Form is required if this report is requested by any party other than the patient or a court ordered subpoena of records. Court Orders do not require additional information, however, patients MUST provide photo identification in person before the report can be released. A copy of his or her photo ID shall be attached to the completed Incident Request Form.

Please return this form, along with a valid HIPAA Authorization signed by the patient, if applicable, in person to:

Williamsburg Township Emergency Services
915 West Main St
Williamsburg, Ohio 45176

EMS Use Only
Incident #_____
Date Recv'd: _____
Date Picked Up: _____
Initials: _____

Please note: It is the EMS policy to fulfill public record requests within ten (10) days of receipt of request. The EMS may require additional time to process more difficult requests and if so, an estimated time frame will be provided to the requestor.

Requestor Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Williamsburg Township EMS
(Name of Patient) (Name of EMS)
to release the following health information: _____

_____

to _____
(Name and title of facility name to receive health information)

_____

For the following purpose: _____

_____

This authorization is in effect until _____ (date or event), when it expires one year from date of signature located below.

_____

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient: _____ Date: _____

Or Signed by Personal Representative:

_____ **Date:** _____
(Print Name and Provide Signature)

On behalf of:

IDENTIFYING INFORMATION

EMS Employee: Request, View, and make a copy of Identification. Attach a copy for EMS records.

Type of ID: _____ (OH Driver's License, State ID Card, Birth Certificate, benefits identification card, managed care card, state or federal employee ID card, etc.

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED

Notarized by: _____

On: _____(Date)

Notary Public Number: _____

NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

PERSONAL REPRESENTATIVE INFORMATION

You **MUST** provide a copy of the legal authority you have to make medical decisions for the patient listed on the EMS report. What authority do you have?

PARENT

GUARDIAN

MEDICAL POWER OF ATTORNEY

CONSERVATOR

EXECUTOR OF WILL

OTHER _____

NOTE: Attaching legal documentation is required to verify that you are the parent, conservator, guardian, executor of a decedent's will, o have medical decision-making authority for the individual.

HIPAA TRAINING ACKNOWLEDGEMENT

This is to certify that I have received and understand Williamsburg Township Emergency Services' HIPAA training. I agree to comply with the HIPAA Privacy Rule and related policies and procedures, applicable to my job. This will be expected as part of my continued employment or association. This Acknowledgement is not an assurance of continued employment or association.

_____

Signature

_____

NAME (Please Print)

_____

DATE

NOTE: MAINTAIN THE ORIGINAL OF THIS ACKNOWLEDGEMENT IN EACH EMPLOYEE'S PERSONNEL FILE.

Authorization to Disclose Specific Protected Health Information

By signing this Authorization, I hereby direct the use of disclosure of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me:

___ Complete Ambulance Run Report ___ Itemized Billing or claim form only ___ Any information requested

and may include information from:

___ Specific Date(s) or Service (specify): __/__/____ __/__/____ or ___ Entire patient file

This information may be used or disclosed by:

_____ (Name of EMS)

and may be disclosed to:

_____

I understanding that I have the right to revoke this Authorization at any time except to the extent that the healthcare provider has already acted in reliance on the Authorization, or if the Authorization was obtained in order to obtain insurance coverage, and other law provides the insurer with the right to contest a claim under the coverage. To revoke this Authorization, I understand that I must do so by written request to:

_____ (Name of EMS)
Attn: Privacy Officer
_____ (Address)
_____ (City/State/Zip)

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to the privacy protections provided by law. I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. I am requesting this information for the following purpose(s):

_____

_____

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This Authorization expires on: ____/___/_____ (not required if no end date desired)

Printed Patient Name: _____

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

Description of Authorized Representative's Authority (check one and attach paperwork):

___ Power of Attorney ____ Executor of Estate ___ Other: _____

Williamsburg Township Emergency Services
Notice of Privacy Practices

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

Effective Date of the Notice: _____

If you have any questions about this notice, please contact:

_____ (Name of EMS)
Attn: Privacy Officer
_____ (Street Address)
_____ (City/State/Zip)
_____ (Phone Number)

Purpose of this Notice: The EMS is required by law to maintain the privacy of certain confidential health care information, known as protected health information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how the EMS is permitted to use and disclose PHI about you. The EMS is also required to abide by the terms of the version of this Notice currently in effect. We are also required by Federal Law to attempt to obtain your signature or initial acknowledging receipt of this form.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment: This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations: This includes quality assurance activities, licensing, training programs, student education, ride-along programs, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising, and certain marketing activities.

Reminders for Scheduled Transports and Information on Other Services: We may also contact you to provide you with a reminder of any scheduled appointments for non-emergency ambulance and medical transportation, or for other information about alternative services we provide or other health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the office; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer listed at the end of this notice. We will normally provide you with access to this information within thirty (30) days of your written request. We may also charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. You will be notified in writing of such denials in addition to any appeal rights that may exist.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, your request must be made in writing and submitted to the attention of the EMS Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for our office;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

The right to request an accounting of our use and disclosures of your PHI. You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or of uses or disclosures made prior to 2007. If you wish to request an accounting of the medical information about you that we have used or disclosed, you should make a request in writing to the EMS Privacy Officer listed at the end of this Notice.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. But if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment. EMS is not required to agree to any restrictions you request, but any restrictions agreed to by EMS Privacy Officer listed at the end of this notice. In your request, you must tell us:

- What information you want to limit;
- Whether you want to limit our use, disclosure or both; and

- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the EMS Privacy Officer listed at the end of this notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, _____. To obtain a paper copy of this notice, send a written request to the EMS Privacy Officer listed at the end of this notice.

Legal Rights and Complaints. This notice will be updated when any significant changes in our privacy practices occur. EMS reserves the right to change or amend this Notice at any time, and the changes will be effective immediately. We also reserve the right to make any changes effective for PHI that we have created or received prior to the effective date of the Notice provision that was changed.

You also have the right to complain to us, or to the Secretary of the Federal Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions or comments, or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Williamsburg Township Emergency Services
Attn: Privacy Officer
915 West Main St
Williamsburg, Ohio 45176
513-724-7744

You can get a copy of the latest version of this notice by contacting the Privacy Officer or any staff member, by visiting our Website _____ (fill in) or by calling us eat _____ (fill in).

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

EMAIL

Email addresses are considered public record under Ohio Law and are not exempt from public-records requirements. If you do not want your email address to be available for release via a public-records request do not send email to this entity or its employees. Instead, contact us by standard mail or telephone.

(NAME OF EMS)
Patient Request for Access Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years prior to the date of the request from EMS, to amend your PHI and to request restrictions on the uses and disclosures of your PHI. I understand that EMS has the right to deny access to portions of your PHI if one of the following conditions are met:

1. The information you requested was compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding: (Not appealable)

2. The information you requested was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. (Not appealable)

3. A license health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person; (Appealable)

4. The protected health information makes reference to another person (other than an health care provider) and a licensed health professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to that person; (Appealable)

5. The request for access is made by you as a personal representative of the individual about whom you are requesting the information, and a licensed health professional has determined, in the exercise of professional judgment, that access by you is reasonably likely to cause harm to the individual or another person. (Appealable)

Signature _____ Request Date: _____

(NAME OF EMS)

Patient Request for Restriction Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years, prior to the date of the request, from EMS, to amend your PHI and to request restrictions to the uses and disclosures of your PHI. **EMS is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by EMS are binding on EMS.**

Please indicate your request for restricted uses and disclosures of your PHI.

_____

_____

_____

_____

Signature: _____ Date: _____

(NAME OF EMS)

Request for Amendment of Protected Health Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to Amend:

Please check the field that represents the type of information you would like to amend. Additional pages may be added if necessary.

Patient Information:

- Name
- Personal Information (i.e. SSN, DOB, Ins. Info., etc.)
- Mailing Address
- Marital Status
- Surrogate Decision Maker or POA
- Other (Other described) _____
- _____
- _____
- _____
- _____

Call Information:

- Medical Condition
- Medications
- Medical History
- Allergies
- Treatments received
- Symptoms
- Hospital Treatment/DX
- Specify which call(s):
- _____, _____,
- _____, _____

Please specifically describe what information you wanted amended. Please ONLY list the new information. (Attach additional sheets if necessary)

EMS is not required to accept your request for amendment and will notify you in writing as to its decision on your request.

Please allow 60 days for the amended information to become effective.

EMS, in its capacity as a health care provider, is entitled to perform and bill for services based on all protected health information in its current form or upon which it has already relied until such time as the amended information becomes effective.

Your signature below indicates that you have agreed to accept these terms as they have been listed and to provide payment, if required, to EMS based on existing protected information until such time that the amendments you have made are effective.

Patient Signature: _____ Date: _____

(NAME OF EMS)

Procedure for Filing Complaints About Protected Health Information

YOU MAY MAKE A COMPLAINT DIRECTLY TO US

You have the right to make a complaint directly to the Privacy Officer of EMS concerning our policies and procedures with respect to the use and disclosure of protected health information (PHI) about you. You may also make a complaint about concerns you have regarding our compliance with any of our established policies and procedures concerning the confidentiality and use of disclosure of your PHI, or about the requirements of the Federal Privacy Rule.

All complaints shall be in writing and should be directed to our Privacy Officer at the following address and phone number:

_____ (Name of EMS)
Attn: Privacy Officer
_____ (Street Address)
_____ (City/State/Zip)
_____ (Phone Number)

YOU MAY ALSO MAKE A COMPLAINT TO THE GOVERNMENT

If you believe EMS is not complying with the applicable requirements of the Federal Privacy Rule you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

(b) Requirements for filing complaints. Complaints under this section must meet the following requirements.

1) A complaint must be filed in writing, either on paper or electronically.

2) A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of the Federal Privacy Rule or the applicable standards, requirements, and implementation specifications of subpart E of part 164 of the Federal Privacy Rule.

3) A complaint must be filed within 180 day of when the complainant knew or should have known that the act or omission complained of occurred, unless the Secretary for good cause shown waives this time limitation.

4) The Secretary may prescribed additional procedures for the filing of complaints, as well as the place and manner of filing, by notice in the Federal Register.

(c) Investigation. The Secretary may investigate complaints. Such investigation may include a review of the pertinent policies, procedures, or practices of the covered entity and of the circumstances regarding any alleged acts or omissions concerning compliance.

EMS

RECORDS

MANUAL

Section 1. EMS INCIDENT REPORT REQUEST INSTRUCTIONS AND FORMS

The department will, from time to time, receive two types of records requests as follows:

The first type will merely be for a record of ambulance runs and/or other public record information that does not contain Protected Health Information (PHI) and does not contain personal identifiers such as Social Security Numbers and dates of birth. These requests will be handled in accordance with Ohio Rev. Code Sec. 149.43 (the Ohio Open Records Law). In most cases, the law favors disclosure of such records; however if the Privacy Officer has legal questions regarding the application of the open records law to a specific request, such questions should be referred to the department's legal counsel for opinion.

The second type of records request will be for records which do contain PHI. Privacy laws and regulations require that our responses to such requests be specific to the record(s) requested and provided only upon proper authorization. For most requests, the following instructions and request and authorization forms will suffice. Section 2. of this manual provides samples of additional types of authorizations that may be presented to the department along with requests for records containing PHI.

Williamsburg Township Emergency Services

EMS INCIDENT REPORT REQUEST INSTRUCTIONS

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Emergency Medical Service (EMS) Reports

- EMS reports are considered confidential medical records, and are protected by privacy laws.
- A patient has a right to a copy of his or her EMS report. The request must be in writing and signed by the patient. A copy of photo identification (drivers license) must accompany and be attached to the request prior to release of the report.
- Most third party requests require either a HIPPA authorization signed by the patient or a court order. However, there are certain exceptions to these requirements including, but not limited to, requests from: the patient's health care decision maker, another healthcare provider currently treating the patient, or a grand jury subpoena.
- A report for a deceased individual may be given by the EMS to the personal representative of the estate upon presentation of the death certificate and court order showing the appointment of the personal representative.
- A report may be released to a healthcare decision maker (or an individual who is authorized to make health care treatment decisions for the patient, including the parent of a minor or an agent pursuant to a healthcare power of attorney).
- Subpoenas from the Prosecutor's Office do not require a HIPAA authorization signed by the patient.
- The EMS report request must be submitted in person to (Name and Address of EMS) unless the request is made by another health care provider, government agency, private accreditation agency, business associate or by court order or subpoena).
- The individual making a report request must provide photo identification.
- The guardian of a minor making a report request must provide proof of legal guardianship.

REQUEST FORM FOR EMS INCIDENT REPORT

PLEASE COMPLETE THIS FORM IN FULL.

- *If the requestor is a court-appointed personal representative of a deceased patient, the requestor MUST include a copy of the death certificate and court order showing the appointment as a personal representative.*
- *If the requestor is a legal guardian of a minor, the requestor must provide proof of legal guardianship (and photo identification).*

The information requested below must be completed in full. Requests without the required information will be returned to sender. If you do not have the necessary incident information, you may contact the Williamsburg Township Emergency Services at 513-724-7744.

REQUESTOR NAME: _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ EMAIL: _____

Date of Incident: _____ Time of Incident: _____

Incident Address: _____

Type of Incident: _____

EMS Incident Report & HIPAA Authorization Forms

A HIPAA Authorization Form is required if this report is requested by any party other than the patient or a court ordered subpoena of records. Court Orders do not require additional information, however, patients MUST provide photo identification in person before the report can be released. A copy of his or her photo ID shall be attached to the completed Incident Request Form.

Please return this form, along with a valid HIPAA Authorization signed by the patient, if applicable, in person to:

Williamsburg Township Emergency Services

915 West Main St
Williamsburg, Ohio 45176

EMS Use Only

Incident #_____
Date Recv'd: _____
Date Picked Up: _____
Initials: _____

Please note: It is the EMS policy to fulfill public record requests within ten (10) days of receipt of request. The EMS may require additional time to process more difficult requests and if so, an estimated time frame will be provided to the requestor.

Requestor Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED

I, _____, hereby authorize Williamsburg Township EMS
(Name of Patient)

to release the following health information: _____

_____

to _____
(Name and title of facility name to receive health information)

_____

For the following purpose: _____

_____

This authorization is in effect until _____ (date or event), when it expires one year from date of signature located below.

_____

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient: _____ Date: _____

Or Signed by Personal Representative:

_____ **Date:** _____
(Print Name and Provide Signature)

On behalf of: _____
Name of Patient

IDENTIFYING INFORMATION

EMS Employee: Request, View, and make a copy of Identification. Attach a copy for EMS records.

Type of ID: _____ (OH Driver's License, State ID Card, Birth Certificate, benefits identification card, managed care card, state or federal employee ID card, etc.

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST

Notarized by: _____

On: _____(Date)

Notary Public Number: _____

NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

PERSONAL REPRESENTATIVE INFORMATION

You **MUST** provide a copy of the legal authority you have to make medical decisions for the patient listed on the EMS report. What authority do you have?

- □ PARENT
- □ GUARDIAN
- □ MEDICAL POWER OF ATTORNEY
- □ CONSERVATOR
- □ EXECUTOR OF WILL
- □ OTHER _____

NOTE: Attaching legal documentation is required to verify that you are the parent, conservator, guardian, executor of a decedent's will, o have medical decision-making authority for the individual.

Section 2. SAMPLE AUTHORIZATIONS

It is not a requirement of this department that our authorization forms be used for records requests. Very often, attorneys, medical care providers and others, have developed their own forms and obtained executed authorizations prior to presenting them to our department.

The forms in this section are representative of documents that may be offered at the time of a specific records request:

Authorization to Disclose Specific Protected Health Information: This is a form currently used by a number of EMS departments. As noted at the bottom of this form, we will attach, for our records, the document or paperwork granting authority to the requester.

Authorization to Disclose Health Information: This is a typical form used by attorneys in the area who may be requesting the medical records for purposes of either an existing or contemplated civil lawsuit. Many of these forms will specifically cite HIPAA language.

Durable Power of Attorney for Health Care: Many states, including Ohio, permit citizens to execute health powers of attorney, granting to another person – usually a close family member – the power to make medical decisions for the patient as well as the right to obtain medical records. A sample of this type of health power of attorney is included in this section; and Article One, Section A. grants the holder the power to gain access to medical records.

Authorization to Disclose Specific Protected Health Information

By signing this Authorization, I hereby direct the use of disclosure of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me:

□ Complete Ambulance Run Report □ Itemized Billing or claim form only □ Any information requested

and may include information from:

□ Specific Date(s) or Service (specify): __/__/____ __/__/____ or □ Entire patient file

This information may be used or disclosed by:

Williamsburg Township Emergency Services and may be disclosed to:

_____

I understanding that I have the right to revoke this Authorization at any time except to the extent that the healthcare provider has already acted in reliance on the Authorization, or if the Authorization was obtained in order to obtain insurance coverage, and other law provides the insurer with the right to contest a claim under the coverage. To revoke this Authorization, I understand that I must do so by written request to:

Williamsburg Township Emergency Services
Attn: Privacy Officer
915 West Main St
Williamsburg, Ohio 45176

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to the privacy protections provided by law. I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. I am requesting this information for the following purpose(s):

_____

_____

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This Authorization expires on: ____/___/_____ (not required if no end date desired)

Printed Patient Name: _____

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

Description of Authorized Representative's Authority (check one and attach paperwork):

□ Power of Attorney □ Executor of Estate □ Other: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

The following individual or organization is authorized to make the disclosure: Williamsburg Township Emergency Services, 915 West Main St Williamsburg, Ohio 45176.

I hereby authorize the above-stated organization or individual to release to _____ _____, copies of all information comprising the entire record for the patient, _____, including but not limited to:

All records of (___ambulance run____) for (___name of patient_____) on _____, 20__.

I understand that the information released may include information relating to sexually transmitted disease, acquired immune deficiency syndrome (AIDS), information concerning testing or treatment of AIDS and AIDS-related conditions, drug or alcohol human immune deficiency virus (HIV), drug-related conditions, alcoholism and/or psychiatric/psychological conditions, including specifically, but not limited to, those records contemplated by 42 U.S.C. Sec. 290 dd-2, 42 U.S.C. Sec. 290 dd-3 and 42 U.S.C. Sec. 290 information may be disclosed to the above-named individual or organization for the purpose of the processing of a claim for bodily injury, emotional harm, wrongful death, medical malpractice, or other claims for damages. Review of the records is also hereby authorized.

To assist in the identification and location of these records, I am providing the following information:

Name:
Soc. Sec. No.:
Date of Birth:

I hereby authorize the use of a photocopy of this release as an original.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so and present my written revocation to the health information management department. I understand that revocation will not apply to information that already has been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that the organization or individual identified above cannot condition treatment, payment enrollment or eligibility for

benefits on whether I sign this authorization. I understand I may inspect or copy the information to be used or disclosed as provided in C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of this health information, I can contact the Privacy Officer or individual at the organization identified above.

_____ _____

Witness

Patient or Legal Representative

Date:_____

THIS RELEASE IS INTENDED TO COMPLY WITH THE HEALTH INFORMATION PROTABILITY AND ACCOUNTABILITY ACT (HIPAA). ACCEPTANCE OF THIS FORM IS INTENDED TO AVOID THE EXPENSE AND INCONVENIENCE OF COMPLYING WITH AN INSTITUTION SEPARATE FORM, OR REQUIRING YOU TO RESPOND TO A SUBPOENA FOR THIS INFORMATION.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint my (relationship) _____, to serve as my agent and to exercise the powers set forth below. In addition, in order to provide for succession in the event my agent cannot continue to serve, I hereby appoint my daughter, Acacia Janzen, to serve as alternate. By this document, I intend to create a Durable Power of Attorney for Health Care. If no agent designated in this document is available or able to serve, I request that my desires as expressed in this document be given full force and effect as a written expression of intent under applicable law.

The following powers granted to my agent shall be immediately effective and shall not be affected by disability of the principal or lapse of time.

I desire that my wishes as expressed herein be carried out through the authority given to my agent by this document despite any contrary feelings, beliefs or opinions of the members of my family, relatives, friends, or guardian of my estate.

ARTICLE ONE
My Agent's General Powers Regarding My Health Care

My agent is authorized, in my agent's sole and absolute discretion, to exercise the powers granted herein relating to matters involving my health and medical care. In exercising such powers, my agent should first try to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner, however rudimentary. My agent is further instructed that if I am unable to give an informed consent to a proposed medical treatment, my agent shall give, withhold or withdraw such consent for me based upon any treatment choices that I have expressed while competent, whether under this document or otherwise. If my agent cannot determine the treatment choice I would want made under the circumstances, then my agent should make such choice for me based upon what my agent believes to be in my best interests. Accordingly, my agent is authorized as follows:

A. Gain Access to Medical Records and Other Personal Information. To request, receive and review any information, verbal or written, regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations, firms or corporations as my agent shall deem appropriate.

B. Employ and Discharge Health Care Personnel. To employ and discharge medical personnel, including, but not limited to, physicians, psychiatrists, dentists, nurses, and therapists as my agent shall deem necessary for my physical, mental and emotional well-being, and to pay them (or cause to be paid to them) reasonable compensation.

C. Give, Withhold or Withdraw Consent to Medical Treatment. To give or withhold consent to any medical procedure, test or treatment, including surgery; to arrange for my hospitalization, convalescent care, hospice or home care; to summon paramedics or other emergency medical personnel and seek emergency treatment for me, as my agent shall deem appropriate; and under circumstances in which my agent determines that certain medical procedures, tests or treatments are no longer of any benefit to me or, where the benefits are outweighed by the burdens imposed, to revoke, withdraw, modify or change consent to such procedures, tests and treatments, as well as hospitalization, convalescent care, hospice or home care which I or my agent may have previously allowed or consented to or which may have been implied due to emergency conditions. My agent's decisions should be guided by taking into account (1) the provisions of this document; (2) any reliable evidence of preferences that I may have expressed on the subject, whether before or after the execution of this document; (3) what my agent believes I would want done in the circumstances as if I were able to express myself; (4) any information given to my agent by the physicians treating me as to my medical diagnosis and prognosis, and the intrusiveness, pain, risks and side effects associated with this treatment.

D. Exercise and Protect My Rights. To exercise my right to privacy and my right to make decisions regarding my medical treatment even though the exercise of my rights might hasten my death or be against conventional medical advice.

E. Authorize Relief from Pain. To consent to and arrange for the administration of pain-relieving drugs of any kind or other surgical or medical procedures calculated to relieve my pain, including unconventional pain-relief therapies which my agent believes may be helpful, even though such drugs or procedures may lead to permanent physical damage, addiction or hasten the moment of (but not intentionally cause) my death.

ARTICLE TWO
My Agent's Powers Regarding Life-Sustaining Medical Treatment

I wish to live and enjoy life as long as possible. However, I do not wish to receive medical treatment which will only postpone the moment of my death from an incurable and terminal condition or prolong an irreversible coma. For purposes of this document, (1) "terminal condition" shall refer to a condition that is reasonably expected to result in my death within twelve (12) months regardless of the treatment that I may receive; and (2) "irreversible coma" shall refer to a permanent loss of consciousness from which there is no reasonable possibility that I will return to a cognitive and sapient life, and shall include, but not be limited to, a persistent vegetative state.

Therefore, if two (2) licensed and qualified physicians who are familiar with my condition have diagnosed and noted in my medical records that:

(1) I am unable to give informed consent to medical treatment that is proposed or available for my condition and my condition is terminal as defined above, or;

(2) I have been in a coma for at least sixty (60) days, and that the coma is irreversible as defined above, then my agent is authorized to;

(a) direct that treatment or procedures which will only postpone the moment of my death or prolong an irreversible coma be withheld or, if previously instituted, direct that they be withdrawn;
(b) direct that procedures other than manual feeding used to provide me with nourishment and hydration (including, for example, all forms of intravenous and parenteral feeding, all forms of tube feeding, and misting) be withheld, or if previously instituted, to direct that they be withdrawn;
(c) sign on my behalf any documents necessary to carry out the powers granted in this article (including waivers or releases of liability required by any health care provider);
(d) direct and consent to the writing of a "No Code" or "Do Not Resuscitate" order by any health care provider; and
(e) order whatever is appropriate to keep me as comfortable and as free of pain as is reasonably possible, including the administration of pain relieving drugs, surgical or medical procedures calculated to relieve my pain, and unconventional pain-relief therapies which my agent believes may be helpful, even though such drugs or procedures may lead to permanent physical damage, addiction or hasten the moment of (but not intentionally cause) my death.

In exercising the powers given my agent under this article, my agent shall follow the instructions of this document and any other subsequent instruction, oral or written, that I may give my agent while I am competent. Notwithstanding such instructions, if my agent cannot determine the treatment choice I would want made under the circumstances, then my agent should make such choice for me based upon what my agent believes to be in my best interest.

Certification _____
(Name of Patient)

ARTICLE THREE
My Agent's Powers Regarding My Care and Control of My Body

My agent is authorized as follows with respect to my care and the control of my body:

A. Provide for my residence. To make all necessary arrangements for me at any hospital, hospice, nursing home, convalescent home or similar establishment and to assure that all my essential needs are provided for at such a facility.
B. Provide for Companionship. To provide for such companionship for me as will meet my needs and preferences at a time when I am disabled or otherwise unable to arrange for such companionship myself.
C. Make advance Funeral Arrangements. To make arrangements for my funeral and such other related arrangements as my agent shall deem appropriate, if I have not done so myself.
D. Make Anatomical gifts. To make anatomical gifts which will take effect at my death to such persons and organizations as my agent shall deem appropriate and to execute such papers and do such acts as shall be necessary, appropriate, incidental or convenient in connection with such gifts.

ARTICLE FOUR
Third Party Reliance

For the purpose of including any individual, organization, or entity (including, but not limited to, any physician, hospital, nursing home, insurer, or other party, all of whom will be referred to in this Article as a "person") to act in accordance with the instructions of my agent as authorized in this document, I hereby represent, warrant and agree that:

A. Reliance on Agent's Authority and Representations. No person who relies in good faith upon the authority of my agent under this document shall incur any liability to me, my estate, my heirs, successors or assigns. In addition, no person who relies in good faith upon any representation my agent may make as to (a) the fact that my agent's powers are then in effect, (b) the scope of my agent's authority granted under this document, (c) my competency at the time this document is executed, (d) the fact that this document had not been revoked, or (e) the fact that my agent continues to serve as my agent shall incur any liability to me, my estate, my heirs, successors or assigns for permitting my agent to exercise any such authority.

B. No Liability for Unknown Revocation or Amendment. If this document is revoked or amended for any reason, I, my estate, my heirs, successors and assigns will hold harmless any person from any loss suffered or liability incurred as a result of such person acting in good faith upon the instructions of my agent prior to the receipt by such person of actual notice of such revocation or amendment.

C. Agent May Act Alone. The powers conferred on my agent by this document may be exercised by my agent alone and my agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. Consequently, all acts lawfully done by my agent hereunder are done with my consent and shall have the same validity and effect as if I were personally present and personally exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns and personal representatives.

D. Release of Information. I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my agent all information or photocopies of any records which my agent may request. If I am incompetent at the time my agent shall request such information, all persons are authorized to treat any such request for information by my agent as the request of my legal representative and to honor such requests on that basis. I hereby waive all privileges which may be applicable to such information and records and to any communication pertaining to me and made in the course of any confidential relationship recognized by law. My agent may also disclose such information to such persons as my agent shall deem appropriate.

E. Resort to Courts. I hereby authorize my agent to seek on my behalf and at my expense:

(a) a declaratory judgment from any court of competent jurisdiction interpreting the validity of this document or any of the acts authorized by this document, but such declaratory judgment shall not be necessary in order for my agent to perform any act authorized by this document; or
(b) mandatory injunction requiring compliance with my agent's instructions by any person obligated to comply with instructions given by my agent; or
(c) actual and punitive damages against any person obligated to comply with instructions given by my agent who negligently or willfully fails or refuses to follow such instructions.

ARTICLE FIVE
Miscellaneous Provisions

The following provisions shall apply to this document:

A. Reimbursement of Costs. My agent shall be entitled to reimbursement for all reasonable costs and expenses actually incurred and paid by my agent on my behalf under any provision of this document, but my agent shall not be entitled to compensation for services rendered hereunder.

B. Execute Documents and Incur Costs in Implementing the Above Powers. My agent shall be entitled to sign, execute, deliver and acknowledge any contract or other document that may be necessary, desirable, convenient or proper in order to exercise any of the powers described in this document and to incur reasonable costs in the exercise of any such powers. In addition, my agent shall render bills for all costs incurred in the exercise of the powers granted in this document to the person then responsible for my financial affairs.

C. Nomination of Guardian. Upon a petition by any person to appoint a guardian of my person, I hereby nominate my agent to serve as the guardian of my person pursuant to the Ohio Revised Statutes. My agent may nominate a successor guardian of my person for consideration by the Court. If my agent is unwilling or unable to serve or to continue to serve in such capacity and fails to nominate a successor guardian of my person, then I nominate my alternate agents to successor guardian of my person, then I nominate my alternate agents to serve in such capacity in the order I have named them in this document.

D. Governing Law. This document shall be governed by the laws of the State of Ohio in all respects, including its validity, construction, interpretation and termination. I intend for this Durable Power of Attorney for Health Care to be honored in any jurisdiction where it may be presented and for any such jurisdiction where it may be presented to refer to Ohio law to interpret and determine the validity of this document and any of the powers granted under this document.

E. Revocation and Amendment. I revoke all prior Durable Powers of Attorney for Health Care that I may have executed and I retain the right to revoke or amend this document and to substitute other agents in your place. Amendments to this documents shall be make in writing by me personally (not by the agent) and they shall be attached to the original of this document.

F. Resignation of Agent. My agent and any alternate agent may resign by the execution of a written resignation delivered to me or, if I am mentally incapacitated, by delivery to the Guardian of my person (other than the agent), the trustee of my revocable trust, and absent such person, then to any person with whom I am residing or who has the care and custody of me, or, in the case of the resignation of an alternate agent, by delivery to my agent.

If my spouse has been appointed my agent or an alternate agent hereunder and subsequent to the execution of this document an action is filed to dissolve our marriage, then the filing of such action shall automatically remove my spouse as agent or alternate agent.

In addition, the incapacity of my agent or any alternate agent shall be deemed to resignation by such individual as agent or alternate agent as the case may be. For purposes of this paragraph, a person's incapacity shall be deemed to exist when the person's incapacity has been declared by a court of competent jurisdiction or when a guardian for such person has been appointed, or upon presentation of a certificate executed by two (2) physicians licensed to practice in the state of such person's residence which states the physicians' opinion that the person is incapable of caring for himself or herself and is physically or mentally incapable of managing his or her personal or financial affairs. The effective date of such incapacity shall be the date of the decree adjudicating the incapacity, the date of the decree appointing the guardian, or the date of the physicians' certificate, as the case may be.

G. Photocopies. My agent is authorized to make photocopies of this document as frequently and in such quantities as my agent shall deem appropriate. All photo copies shall have the same force and effect this document placed in my medical records if such a copy does not already constitute a part of my medical records.

H. Severability. If any part of any provision of this document shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining parts of such provision or the remaining provisions of this document.

I. Exculpation. My agent and my agent's estate, heirs, successors and assigns are hereby released and forever discharged by me, my estate, my heirs, successors and assigns from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my agent, except for willful misconduct or gross negligence.

J. Waiver of Bond. I specifically request that no bond be required of my agent or successor agent named herein.

I CERTIFY THAT I HAVE READ THE PROVISIONS OF THIS INSTRUMENT AND THAT SUCH PROVISIONS HAVE BEEN EXPLAINED TO ME TO MY SATISFACTION, IN PARTICULAR, ARTICLE TWO, AS IS EVIDENCED BY MY SIGNATURE AT THE END OF ARTICLE TWO, THAT I UNDERSTAND SUCH PROVISIONS AND THAT SUCH PROVISIONS STATE MY WISHES AND DESIRES UNDER THE CIRCUMSTANCES DESCRIBED.

I execute this Durable Power of Attorney for Health Care on this _____ day of _____, 20_____, at Clermont County, Ohio.

_____
(Name of Patient)

STATE OF OHIO
COUNTY OF CLERMONT, SS:

Before me, a Notary Public in and for the State of Ohio, personally appeared the above-named _____, who acknowledged that he/she did sign the foregoing instrument and that the same is his/her free and voluntary act and deed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal at Clermont County, Ohio, this ____ day of _____, 20___.

_____
Notary Public – State of Ohio
My Commission Expires:_____

Section 3. NOTICE OF PRIVACY PRACTICES

The enclosed Notice of Privacy Practices is posted in our physical locations and on our website. Given the emergency nature of our department, we recognize that it will not always be possible to obtain from every patient a signed acknowledgement of receipt of notice of privacy practices. However, frequent users of our service are specifically provided with copies of this notice.

Privacy regulations also grant to our patients certain access rights, rights to request restriction on dissemination, requests to amend the PHI, and the procedure for filing complaints. Forms for all of these patient rights are enclosed following the notice.

Williamsburg Township Emergency Services

Notice of Privacy Practices

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

Effective Date of the Notice: _____

If you have any questions about this notice, please contact:

Williamsburg Township Emergency Services

Attn: Privacy Officer
915 West Main St
Williamsburg, Ohio 45176
513-724-7744

Purpose of this Notice: The EMS is required by law to maintain the privacy of certain confidential health care information, known as protected health information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how the EMS is permitted to use and disclose PHI about you. The EMS is also required to abide by the terms of the version of this Notice currently in effect. We are also required by Federal Law to attempt to obtain your signature or initial acknowledging receipt of this form.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment: This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations: This includes quality assurance activities, licensing, training programs, student education, ride-along programs, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not

individually identify you for data collection purposes, fundraising, and certain marketing activities.

Reminders for Scheduled Transports and Information on Other Services: We may also contact you to provide you with a reminder of any scheduled appointments for non-emergency ambulance and medical transportation, or for other information about alternative services we provide or other health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the office; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer listed at the end of this notice. We will normally provide you with access to this information within thirty (30) days of your written request. We may also charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. You will be notified in writing of such denials in addition to any appeal rights that may exist.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, your request must be made in writing and submitted to the attention of the EMS Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for our office;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

The right to request an accounting of our use and disclosures of your PHI. You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or of uses or disclosures made prior to 2007. If you wish to request an accounting of the medical information about you that we have used or disclosed, you should make a request in writing to the EMS Privacy Officer listed at the end of this Notice.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. But if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment. EMS is not required to agree to any restrictions you request, but any restrictions agreed to by EMS Privacy Officer listed at the end of this notice. In your request, you must tell us:

- What information you want to limit;
- Whether you want to limit our use, disclosure or both; and
- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the EMS Privacy Officer listed at the end of this notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, _____. To obtain a paper copy of this notice, send a written request to the EMS Privacy Officer listed at the end of this notice.

Legal Rights and Complaints. This notice will be updated when any significant changes in our privacy practices occur. EMS reserves the right to change or amend this Notice at any time, and the changes will be effective immediately. We also reserve the right to make any changes effective for PHI that we have created or received prior to the effective date of the Notice provision that was changed.

You also have the right to complain to us, or to the Secretary of the Federal Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions or comments, or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Williamsburg Township Emergency Services

Attn: Privacy Officer
915 West Main St
Williamsburg, Ohio 45176
513-724-7744

You can get a copy of the latest version of this notice by contacting the Privacy Officer or any staff member, by visiting our Website _____ (fill in) or by calling us at 513-724-7744

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

EMAIL

Email addresses are considered public record under Ohio Law and are not exempt from public-records requirements. If you do not want your email address to be available for release via a public-records request do not send email to this entity or its employees. Instead, contact us by standard mail or telephone.

Williamsburg Township Emergency Services
Patient Request for Access Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years prior to the date of the request from EMS, to amend your PHI and to request restrictions on the uses and disclosures of your PHI. I understand that EMS has the right to deny access to portions of your PHI if one of the following conditions are met:

1. The information you requested was compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding: (Not appealable)

2. The information you requested was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. (Not appealable)

3. A license health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person; (Appealable)

4. The protected health information makes reference to another person (other than an health care provider) and a licensed health professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to that person; (Appealable)

5. The request for access is made by you as a personal representative of the individual about whom you are requesting the information, and a licensed health professional has determined, in the exercise of professional judgment, that access by you is reasonably likely to cause harm to the individual or another person. (Appealable)

Signature _____ Request Date: _____

Williamsburg Township Emergency Services

Patient Request for Restriction Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years, prior to the date of the request, from EMS, to amend your PHI and to request restrictions to the uses and disclosures of your PHI. **EMS is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by EMS are binding on EMS.**

Please indicate your request for restricted uses and disclosures of your PHI.

_____

_____

_____

_____

Signature: _____ Date: _____

Williamsburg Township Emergency Services
Request for Amendment of Protected Health Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to Amend:

Please check the field that represents the type of information you would like to amend. Additional pages may be added if necessary.

Patient Information:

- □ Name
- □ Personal Information (i.e. SSN, DOB, Ins. Info., etc.)
- □ Mailing Address
- □ Marital Status
- □ Surrogate Decision Maker or POA
- □ Other (Other described) _____

_____

_____

_____

_____

Call Information:

- □ Medical Condition
- □ Medications
- □ Medical History
- □ Allergies
- □ Treatments received
- □ Symptoms
- □ Hospital Treatment/DX
- □ Specify which call(s):

_____, _____,

_____, _____

Please specifically describe what information you wanted amended. Please ONLY list the new information. (Attach additional sheets if necessary)

EMS is not required to accept your request for amendment and will notify you in writing as to its decision on your request.

Please allow 60 days for the amended information to become effective.

EMS, in its capacity as a health care provider, is entitled to perform and bill for services based on all protected health information in its current form or upon which it has already relied until such time as the amended information becomes effective.

Your signature below indicates that you have agreed to accept these terms as they have been listed and to provide payment, if required, to EMS based on existing protected information until such time that the amendments you have made are effective.

Patient Signature: _____ Date: _____

Williamsburg Township Emergency Services
Procedure for Filing Complaints About Protected Health Information

YOU MAY MAKE A COMPLAINT DIRECTLY TO US

You have the right to make a complaint directly to the Privacy Officer of EMS concerning our policies and procedures with respect to the use and disclosure of protected health information (PHI) about you. You may also make a complaint about concerns you have regarding our compliance with any of our established policies and procedures concerning the confidentiality and use of disclosure of your PHI, or about the requirements of the Federal Privacy Rule.

All complaints shall be in writing and should be directed to our Privacy Officer at the following address and phone number:

Williamsburg Township Emergency Services

Attn: Privacy Officer
915 West Main St
Williamsburg, Ohio 45176
513-724-7744

YOU MAY ALSO MAKE A COMPLAINT TO THE GOVERNMENT

If you believe EMS is not complying with the applicable requirements of the Federal Privacy Rule you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

(b) Requirements for filing complaints. Complaints under this section must meet the following requirements.

1) A complaint must be filed in writing, either on paper or electronically.

2) A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of the Federal Privacy Rule or the applicable standards, requirements, and implementation specifications of subpart E of part 164 of the Federal Privacy Rule.

3) A complaint must be filed within 180 day of when the complainant knew or should have known that the act or omission complained of occurred, unless the Secretary for good cause shown waives this time limitation.

4) The Secretary may prescribed additional procedures for the filing of complaints, as well as the place and manner of filing, by notice in the Federal Register.

(c) Investigation. The Secretary may investigate complaints. Such investigation may include a review of the pertinent policies, procedures, or practices of the covered entity and of the circumstances regarding any alleged acts or omissions concerning compliance.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record No. _____

Address: _____

EMS Name: _____

I have been given a copy of (EMS)'s *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that (EMS) has the right to change this *Notice* at any time. I may obtain a current copy by contacting the EMS Privacy Official, or by visiting the (EMS) web site at _____.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

   _____

2. Described the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement*:

   _____

   _____

   Completed by:

   _____ _____

   Signature of EMS Representative Date

   _____

   Print Name

File original in resident's Business Office Record.

Section 4. BUSINESS ASSOCIATE AGREEMENT

Federal laws and regulations require our department to enter into written contracts with all of our business associates who provide data transmission services for PHI or subcontract by either creating, receiving, maintaining or transmitting PHI.

Most often, business associates falling into this definition are outside billing services and their subcontracted collection agents. However, a business associate may also be a person or entity that provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services which involve the use of disclosure of PHI.

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is made and entered into by and between Williamsburg Township Emergency Services, herein after referred to as the "Covered Entity", and Medicount Management, hereinafter referred to as the "Business Associate".

WHEREAS, the Covered Entity has entered into a contract with the Business Associate wherein Business Associate provides billing services to the Covered Entity; and

WHEREAS, both parties to this agreement desire to comply with all statutory and regulatory requirements pertaining to health information privacy;

NOW THEREFORE, in consideration of the premises, the parties' contractual relationship, and the mutual agreements set forth herein, the parties agree as follows.

Specific definitions:

"**Business Associate**" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement shall mean Medicount Management.

"**Covered Entity**" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement shall mean _____(EMS)_____.

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

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of

unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;

[The parties may wish to add additional specificity regarding the breach notification obligations of the business associate, such as a stricter timeframe for the business associate to report a potential breach to the covered entity and/or whether the business associate will handle breach notifications to individuals, the HHS Office for Civil Rights (OCR), and potentially the media, on behalf of the covered entity.]

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(e) Make available protected health information in a designated record set to the [Choose either "covered entity" or "individual or the individual's designee"] as necessary to satisfy covered entity's obligations under 45 CFR 164.524;

[The parties may wish to add additional specificity regarding how the business associate will respond to a request for access that the business associate receives directly from the individual (such as whether and in what time and manner a business associate is to provide the requested access or whether the business associate will forward the individual's request to the covered entity to fulfill) and the timeframe for the business associate to provide the information to the covered entity.]

(f) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;

[The parties may wish to add additional specificity regarding how the business associate will respond to a request for access that the business associate receives directly from the individual (such as whether and in what time and manner a business associate is to act on the request for amendment or whether the business associate will forward the individual's request to the covered entity) and the timeframe for the business associate to incorporate any amendments to the information in the designated record set.]

(g) Maintain and make available the information required to provide an accounting of disclosures to the [Choose either "covered entity" or "individual"] as necessary to satisfy covered entity's obligation under 45 CFR 164.528;

[The parties may wish to add additional specificity regarding how the business associate will respond to a request for an accounting of disclosures that the business associate receives directly from the individual (such as whether and in what time and manner the business associate is to provide the accounting of disclosures to the individual or whether the business associate will forward the request to the covered entity) and the timeframe for the business associate to provide information to the covered entity.]

(h) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

Permitted Uses and Disclosures by Business Associate

(a) Business associate may only use or disclose protected health information

[Option 1 – Provide a specific list of permissible purposes.]

[Option 2 – Reference an underlying service agreement, such as "as necessary to perform the services set forth in Service Agreement.]

[In addition to other permissible purposes, the parties should specify whether the business associate is authorized to use protected health information to de-identify the information in accordance with 45 CFR 164.154(a)-(c). The parties also may wish to specify the manner in which the business associate will de-identify the information and the permitted uses and disclosures by the business associate of the de-identified information.]

(b) Business associate may use or disclosure protected health information as required by law.

(c) Business associate agrees to make uses and disclosures and requests for protected health information

[Option 1] consistent with covered entity's minimum necessary policies and procedures.

[Option 2] subject to the following minimum necessary requirements: [Include specific minimum necessary provisions that are consistent with the covered entity's minimum necessary policies and procedures.

(d) Business associate may not use or disclosure protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity [if Agreement permits the business associate to use or disclose protected health information for its own management and administration and legal responsibilities or for data aggregation services as set forth in optional provisions (e), (f), or (g) below, then add "except for the specific uses and disclosures set forth below."]

(e) [Optional] Business associate may use protected health information for the proper management and administration of the business associate or to carry out the legal responsibilities of the business associate.

(f) [Optional] Business associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosure are required by law, or business associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies business associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(g) [Optional] Business associate may provide data aggregation services relating to the health care operations of the covered entity.

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

(a) [Optional] Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

(b) [Optional] Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

(c) [Optional] Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is

required to abide by under 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

[Optional] Covered entity shall not request business associate to use or disclose protected health information in any manner that would not be permissible under Subpart E or 45 CFR Part 164 if done by covered entity. [Include an exception if the business associate will use or disclose protected health information for, and the agreement includes provisions for, data aggregation or management and administration and legal responsibilities of the business associate.]

Term and Termination

(a) Term. The Term of the Agreement shall be effective as of [Insert effective date], and shall terminate on [Insert termination date or event] or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Business associate authorizes termination of this Agreement by covered entity, if covered entity determines business associate has violated a material term of the Agreement [and business associate has not cured the breach or ended the violation within the time specified by covered entity]. [Bracketed language may be added if the covered entity wishes to provide the business associate with an opportunity to cure a violation or breach of the contract before termination for cause.]

(c) Obligations of Business Associate Upon Termination.

[Option 1 – if the business associate is to return or destroy all protected health information upon termination of the agreement]

Upon termination of the Agreement for any reason, business associate shall return to covered entity [or, if agreed to by covered entity, destroy] all protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, that the business associate still maintains in any form. Business associate shall retain no copies of the protected health information.

[Option 2 – if the agreement authorizes the business associate to use or disclose protected health information for its own management and administration or to carry out its legal responsibilities and the business associate needs to retain protected health information for such purposes after termination of the agreement]

Upon termination of this Agreement for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

1. Retain only that protected health information which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;

2. Return to covered entity [or, if agreed to by covered entity, destroy] the remaining protected health information that the business associate still maintains in any form;

3. Continue to use appropriate safeguards and comply with Subpart C of 45 CRF Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the protected health information;

4. Not use or disclose the protected health information retained by business associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at [Insert section number related to paragraphs (e) and (f) above under "Permitted Uses and Disclosures By Business Associate"] which applied prior to termination; and

5. Return to covered entity [or, if agreed to by covered entity, destroy] the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

[The agreement also could provide that the business associate will transmit the protected health information to another business associate of the covered entity at termination and/or could add terms regarding a business associate's obligations to obtain or ensure the destruction of protected health information created, received, or maintained by subcontractors.]

(d) Survival. The obligations of business associate under this Section shall survive the termination of this Agreement.

Miscellaneous

Any reference or references in this Agreement to a section of the HIPAA Rules means the section or sections as in effect or as amended.

The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

IN TESTIMONY WHEREOF, the Parties have executed this Business Associate Agreement this ____ day of _____, 20_____.

Covered Entity	Business Associate
By:_____	By:_____
Title:_____	Title:_____

Section 5. HIPAA TRAINING ACKNOWLEDGEMENT

All personnel in our workforce who handle PHI are required to obtain HIPAA training. In most cases, certificates are presented to those who complete training sessions. We will maintain both the certificates of completion and the enclosed HIPAA TRAINING ACKNOWLEDGEMENT in each employee's personnel file.

HIPAA TRAINING ACKNOWLEDGEMENT

This is to certify that I have received and understand Williamsburg Township Emergency Services HIPAA training. I agree to comply with the HIPAA Privacy Rule and related policies and procedures, applicable to my job. This will be expected as part of my continued employment or association. This Acknowledgement is not an assurance of continued employment or association.

_____

Signature

_____

NAME (Please Print)

_____

DATE

NOTE: MAINTAIN THE ORIGINAL OF THIS ACKNOWLEDGEMENT IN EACH EMPLOYEE'S PERSONNEL FILE.

Section 6. LIMITED PHI USE FOR MARKETING/FUNDRAISING

It is the policy of our department not to use identifying information in our PHI for marketing or fundraising purposes. Further, it is our policy not to sell or share such information with outside entities.

Nonetheless, it is entirely possible that persons for whom we have provided services will receive fundraising communications from our department. Therefore, the following policy is established for all such communications.

FUNDRAISING COMMUNICATIONS

Another modification to the HIPAA rules is found in 45 CFR Part 164.514(f) regarding fundraising communications by covered entities:

> "With each fundraising communication to an individual under the paragraph, a covered entity must provide the individual with a clear and conspicuous opportunity to elect not to receive any further fundraising communications." (emphasis added)

Such individuals must be advised of the method of "opting out" with no undue burden at not more than a nominal cost.

A method must also be provided for the individual to opt back in, should he or she want such communications in the future.

Section 7. SECURITY BREACHES/SANCTION POLICY

Each security breach involving 500 or more records (by either our department or any business associate of ours) requires the following:

(1) Within sixty (60) days of such breach, we shall notify each person whose record was involved in the breach.
(2) Upon discovery of such breach, we shall self-report the incident to the Secretary of HHS.
(3) Local media shall also be advised.

In addition, civil monetary penalties may be assessed against our department and are summarized in this section.

Our workforce shall also be subject to the sanction policy set forth in this section.

SECURITY BREACHES/SANCTION POLICY

HHS has established civil money penalties which increase based upon increasing levels of culpability defined as "reasonable cause", "reasonable diligence" and "willful neglect."

The following table sets forth the penalty amounts which are cumulative.

Categories of Violations and Respective Penalty Amounts Available

Violation category – Section 1176(a)(1)	Each Violation	All such violations of an identical provision in a calendar year
(A) Did Not Know	$ 100-$50,000	$ 1,500,000
(B) Reasonable Cause	1,000-50,000	1,500,000
(C) (i) Willful Neglect-Corrected	10,000-50,000	1,500,000
(C)(ii) Willful Neglect-Not Corrected	50,000	1,500,000

In addition to entity liability, there is potential personal liability for monetary penalties.

BREACH NOTIFICATION

"Breach" is the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information.

45 CFR 160.310

As a covered entity we, on behalf of our department and our business associates, will bear the following responsibilities:

(a) Provide records and compliance reports to the Secretary of HHS.
(b) Cooperate with complaint investigations and compliance reviews.
(c) Permit HHS access to information.
(d) Notify HHS and individuals of breaches.

SANCTION POLICY

Pursuant to 45 CFR 164.308, we adopt the following sanction policy I order to apply appropriate sanctions against employees who fail to comply with our security policies and procedures:

(1) "Willful neglect" resulting in a breach may result in termination of employment.
(2) Causing a breach that was reasonably foreseeable may result in a suspension without pay.
(3) A breach that was not clearly foreseeable may result in a reprimand and additional privacy training at the employee's expense.

In addition to monetary sanctions imposed by HHS, a breach by a business associate may result in termination of our contract with the business associate.

SANCTION POLICY

Pursuant to 45 CFR 164.308, we adopt the following SANCTION POLICY which shall apply to all members of our workforce who fail to comply with this department's security policies and procedures. As a general statement of our position, we will endeavor to apply disciplinary sanctions in accordance with the various degrees of negligence outlined in the regulations. In that regard, "willful neglect" may result in the most severe sanctions, including potential termination of employment. One causing a breach that was reasonably foreseeable may also receive severe sanctions. Breaches that were not foreseeable may result in the lowest sanctions which may include reprimands as well as additional privacy training.

Breaches by business associates may result in termination of our contractual relationship.

The following outline sets for the level of infraction, a description and some examples of the infraction and the general range of discipline that will be considered for each level of infraction. The examples set forth below are not all-encompassing as factual situations will vary from case-to-case. Further, in cases involving termination, the seriousness of the breach will be considered "just cause" for the cessation of the employment. Naturally, any severe infraction or series of infractions that result in termination will be handled in accordance with all requirements under state and federal law and under contract and/or collective bargaining agreements.

Level of Infraction	Description/Examples	Range of Discipline
Level 1 Unintentional Resulting in no reportable breach	Occurs when employee unintentionally or carelessly accesses, reviews or reveals PHI to him/herself or others without a legitimate need to know or beyond the minimum necessary level of access assigned to his/her role. **Examples** Discussion of PHI in public area (cafeterias, elevators, etc.) Typing in wrong MR# or Patient Name and viewing wrong patient's information. Leaving PHI accessible within public area (e.g., unattended computer, medical records/schedules in meeting rooms, etc.)	Verbal Reminder and/or additional HIPAA Education.

Level 2 Unintentional, Resulting in reportable breach	Occurs when employee unintentionally or carelessly access, reviews or reveals PHI to him/herself or others without a legitimate need to know or beyond the minimum necessary level of access assigned to his/her role and such action results in a reportable breach. **Examples** Mailing/faxing errors – sending another patient's documentation to another person/entity resulting in a breach. Inappropriately accessing/disclosing patient's medical information (minimum necessary rule not followed, email sensitive information, access to sensitive information outside of role). Password compromised by sharing it and patient medical information was accessed. EMR left open and patient medical information was accessed.	Varies depending on circumstances: Written reprimand, final warning or unpaid leave. Severe and multiple infractions that lead to breaches may result in termination.
Level 3 Intentional	Occurs when employee accesses, reviews, or discusses PHI for personal gain or with malicious intent. Willful and gross negligent use and/or disclosure of PHI, destruction of PHI, or knowingly violating state or federal laws protecting privacy and security of PHI. **Examples** Inappropriately accessing medical records of family, friends or prominent people. Unauthorized and intentional disclosure of patient information to a thirty party.	Varies depending on circumstances: Written reprimand, final warning or unpaid leave. Severe and multiple infractions that lead to breaches may result in termination.

Section 8.

GLOSSARY

GLOSSARY

Authorization: Means a patient's statement of agreement to the use or disclosure of Protected Health Information to a third party.

Business Associate: Includes an entity providing data transmission services for PHI or subcontracts by either creating, receiving, maintaining or transmitting PHI. A business associate might also be a person or entity that provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services involving the use or disclosure of PHI.

Covered Entity: Means health care provider who transmits health care information using one of the transaction standards defined by the Department of Health and Human Services. An example of this would be billing Medicare and Medicaid electronically for services.

Department Of Health And Human Services: The federal agency charged with the development, statement and implementation of the HIPAA Privacy Rule.

Disclosure: Means the release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.

Electronic Media: Means electronic storage material on which data is or may be recorded electronically, including hard drives and removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card.

Fundraising: An organized campaign by a private, non-profit or charitable organization designed to reach out to certain segments of the population or certain identified populations in an effort to raise monies for their organization or for a specific project or purpose espoused by their organization.

HIPAA: Refers to the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996, in particular the portion of the Act known as Administrative Simplification (Subpart F) dealing with the privacy of individually identifiable health information.

Individually Identifiable Health Information (IIHI): Any information, including demographic information, collected from an individual that:

1. Is created or received by a health care provider, health plan, employer or health care clearinghouse; and

2. Releases to the past, present or future physical or mental health or condition of an individual, and
    a. Identifies the individual; or
    b. With respect to which there is reasonable basis to believe that the information can be used to identify the individual.

Minimum Necessary: The least amount of Protected Health Information needed to achieve the intended purpose of the use or disclosure. A covered entity is required to limit the amount of Protected Health Information it uses, discloses or requests to the minimum necessary to do the job.

Notice of Privacy Practices: A document required by HIPAA that provides the patient with information on how the EMS generally uses a patient's Protected Health Information and what the patient's rights are under the Privacy Rule.

PHI: Protected Health Information includes all written and electronic documentation of the health care services provided to an identifiable individual and:

1. Is created or received by a health-care provider, health plan, employer or health-care clearinghouse; and

2. Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and

    a. That identifies the individual; or
    b. There is a reasonable basis to believe the information can be used to identify the individual.

Privacy Officer: The person designated by the organization who is responsible for development and implementation of the HIPAA policies and procedures. The Privacy Officer serves as a resource to assist each EMS' Privacy Official in implementing HIPAA policies and procedures. HIPAA requires that each covered entity appoint a Privacy Official.

Subpoena (2 Kinds): A process to cause a witness to appear and give testimony, commanding him or her to lay aside all pretenses and excuses, and appear before a court or magistrate therein named at a time therein mentioned to testify for the party named under a penalty thereof.

Duces Tecum – A request for witnesses to appear and bring specified documents and other tangible items. The subpoena *duces tecum* requires the individual to appear in court with the requested documents, or simply turn over those documents to the court or to counsel requesting the documents.

General Subpoena (AKA Ad Testificandum) – A command to appear in court at a certain time and place to give testimony regarding a certain matter, for example, to testify that the record was kept in the normal course of business.

Workforce: Employees, volunteers, trainees and other persons whose conduct, in the performance of work for the EMS, is under the direct control of the EMS, whether or not they are paid. Members of the workforce are not business associates.