

ACCOUNTING OF DISCLOSURES

Individual Name: _____

Individual Social Security Number: _____

Date request received	Person making request	Date of Disclosure	Name and Address of Recipient of PHI	Description of PHI disclosed	Purpose of Disclosure (or copy of written request)	Name of Staff processing request

INDIVIDUAL REQUEST FOR PROTECTED HEALTH INFORMATION

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

Name: (First/Middle/Last) _____

Address: (Street/City/State/Zipcode) _____

Date of Birth: (Month/Day/Year) _____

Social Security Number: _____ Date of Request: _____

I REQUEST THE COUNTY TO PROVIDE ME ACCESS TO THE FOLLOWING PHI ABOUT ME:

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

I REQUEST ACCESS TO MY PHI FOR THE DATES COVERING THE FOLLOWING TIME PERIOD(S):

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

I WOULD LIKE TO OBTAIN THE REQUESTED PHI IN THE FOLLOWING FORMAT:

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

I UNDERSTAND THE COUNTY MAY CHARGE A REASONABLE FEE FOR THE COSTS OF COPYING, MAILING OR OTHER SUPPLIES ASSOCIATED WITH MY REQUEST.

Signature of Individual Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

Signature of Personal Representative Date

Legal Authority of the Personal Representative

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

YOUR REQUEST TO ACCESS THE FOLLOWING PROTECTED HEALTH INFORMATION (PHI),

- Medical Records
- Billing Records
- Other _____

FOR PHI COVERING THE DATES OF: ____/____/____ through ____/____/____

IN THE FOLLOWING FORMAT:

- Copies of requested information (Cost \$____.____)
- Inspection of my health information at [Name of Organization].

HAS BEEN:

- Accepted
[List procedure for receiving copies or a date to inspect the PHI at the facility here]
- Denied

Reason for Denial:

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

- The PHI requested makes reference to someone else and is likely to cause that person serious harm;
- As a personal representative it is believed that access to the requested PHI may subject the individual you represent to domestic violence, abuse or neglect or may endanger their life or is not in the best interest of the individual represented.

Other: _____

Staff Signature: _____ Date: _____

Date Request Received: _____

REQUEST FOR REVIEWS

You may have this decision reviewed by sending a written request to: [Contact Name, Title, Name of Organization, Address and Telephone Number]. The request must be received within 7 days from the above date. The review process is described on the reverse.

REVIEW PROCEDURE

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

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

REQUEST FOR ACCOUNTING OF DISCLOSURES

Name: (First/Middle/Last) _____

Address: (Street/City/State/Zipcode) _____

Date of Birth: _____ Social Security number: _____

Date of Request: _____

I REQUEST AN ACCOUNTING OF ALL DISCLOSURES FOR THE FOLLOWING TIME PERIOD: (note: the maximum time period that can be requested is six years prior to the date of your request but not for time periods prior to April 14, 2003):

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

I REQUEST THE ACCOUNTING BE SENT TO THE FOLLOWING ADDRESS:

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

I UNDERSTAND THE FOLLOWING: (check one)

_____ There is no fee for this request

_____ There is a fee for this request

I UNDERSTAND THE ACCOUNTING I HAVE REQUESTED WILL BE PROVIDED TO ME WITHIN 60 DAYS OF THIS REQUEST UNLESS I AM NOTIFIED IN WRITING THAT AN EXTENSION OF UP TO 30 DAYS IS NEEDED.

Signature of Individual

Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE:

Signature of Personal Representative

Date

Legal Authority of the Personal Representative

For County Use:

Date request received: _____ Date accounting sent: _____

Extension requested: _____ No _____ Yes - If yes, give reason: _____

_____ Individual notified in writing of extension

Name of individual processing request: _____

April 14, 2003
County

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

Name: (First/Middle/Last) _____

Address: (Street/City/State/Zipcode) _____

Date of Birth: _____ Social Security number: _____

Date of Request: _____

Date of entry to be amended: _____

Type of entry to be amended: _____

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

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

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

Signature of Individual

Date

*April 14, 2003
County*

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

Signature of Personal Representative

Date

Legal Authority of Personal Representative

For County Use:

Date Received _____ Accepted _____ Denied _____

If denied, check reason for denial:

_____ PHI is accurate and complete

_____ PHI was not created at this organization

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

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

_____ If denied, individual was informed of denial in writing

_____ If accepted, individual was informed of acceptance

Name/title of Individual processing this request: _____

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

Name: (First/Middle/Last) _____

Address: (Street/City/State/Zipcode) _____

Date of Birth: (month/day/year) _____ Social Security Number: _____

Date of Request: _____

I REQUEST THE COUNTY TO COMMUNICATE CONFIDENTIAL INFORMATION TO ME IN THE FOLLOWING MANNER:

Telephone communication at the following telephone number: _____

_____ Leave a message on an answering machine at this number

_____ Do not leave a message on an answering machine at this number

Written communication to be mailed to the following address:

Other: _____

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

Signature of Individual

Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

Signature of Personal Representative

Date

Legal authority of Personal Representative

For County Use:

_____ Accept request for alternative communication

_____ Reject request for alternative communication. Reason rejected: _____

Name/Title of individual processing this request: _____

Date request processed: _____

*April 14, 2003
County*

EMPLOYEE CONFIDENTIALITY AGREEMENT

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

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

Date

Employee signature

Department

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

Signature of individual administering agreement

Date

CONFIDENTIAL REPORT OF CONCERN

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

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

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

Date of this report: _____

Name of person making this report (optional): _____

Description of the violation(s): _____

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

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

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

Department where the incident occurred: _____

Date(s) of the incident: _____

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

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

COMPLIANCE REPORT INVESTIGATION FORM

Date of reported concern: _____

Name of person who received the report: _____

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

Date(s) of investigation: _____

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

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

Description of documents reviewed: _____

Findings: _____

Plan of correction: _____

Signature of Privacy Officer

April 14, 2003
County

**AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

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

THE FOLLOWING PERSON(S) OR ENTITY SHALL:

Name of Person(s) or Entity: _____

Address of Person(s) or Entity: _____

TO DISCLOSE THE FOLLOWING INFORMATION FROM THE HEALTH RECORDS OF:

Name: (First/Middle/Last) _____

Address: (Street/City/ State/Zipcode) _____

Birthdate: (Month/Day/Year) _____ Social Security #: _____

Telephone Number: (Home) _____ (Work) _____

THIS INFORMATION SHALL BE DISCLOSED TO THE FOLLOWING PERSON(S) OR ENTITY:

Name of Person(s) or Entity: _____

Address of Person(s) or Entity: _____

THE INFORMATION DISCLOSED SHALL COVER HEALTH CARE FOR THE FOLLOWING PERIOD(S) OF TIME:

From: (month/date/year) _____ To: (month/date/year) _____

From: (month/date/year) _____ To: (month/date/year) _____

THE INFORMATION SHALL BE DISCLOSED FOR THE FOLLOWING PURPOSE(S):

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

THE FOLLOWING INFORMATION SHALL BE RELEASED:

I UNDERSTAND THAT THIS WILL INCLUDE INFORMATION RELATING TO: (Initial, if applicable)

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

_____ Behavioral health service/psychiatric care.

_____ Treatment for alcohol and/or drug abuse.

AFFIRMATION OF AUTHORIZATION:

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

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

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

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

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

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

Signature of the Individual

Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

Signature of personal representative

Date

Legal authority of personal representative

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.***

If you have any questions about this Notice of Privacy Practices contact the County's Privacy Officer:

[Insert Name of Privacy Contact]

This Notice of Privacy Practices describes how the County may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

The County is required to abide by the terms of this Notice of Privacy Practices. The County may change the terms of this notice, at any time. The new notice will be effective for all protected health information that the County maintains at that time. Upon request, the County will provide you with any revised Notice of Privacy Practices.

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by the County for the purpose of providing or accessing health care services or you. Your protected health information may also be used and disclosed to pay your health care bills and to support the business operation of the County.

The following categories describe ways that the County is permitted to use and disclose health care information. Examples of types of uses and disclosures are listed in each category. Not every use or disclosure for each category is listed; however, all of the ways the County is permitted to use and disclose information falls into one of these categories:

1) Treatment:

The County may use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, the County would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example is that protected health information may be provided to a facility to which you have been referred to ensure that the facility has the necessary information to treat you.

2) Payment

The County may use and disclose health care information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. The County may also discuss your protected health information about a service you are going to receive to determine whether you are eligible for the service, and for undertaking utilization review activities. For example, authorizing a service may require that your relevant protected health information be discussed with a provider to determine your need and eligibility for the service.

3) Healthcare Operations

The County may use or disclose, as-needed, your protected health information in order to support its business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, the County may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or to provide information about alternate services or other health-related benefits.

The County may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the County. Whenever an arrangement between the County and a business associate involves the use or disclosure of your protected health information, the County will have a written contract that contains terms that will protect the privacy of your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that the County has taken an action in reliance on the use or disclosure indicated in the authorization.

The County may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then the County may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

1) Others Involved in Your Healthcare

Unless you object, the County may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, the County may disclose such information as necessary if the County, based on its professional judgment, determines that it is in your best interest. The County may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, the County may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2) Emergencies

The County may use or disclose your protected health information in an emergency treatment situation. If this happens, The County shall try to obtain your acknowledgment of receipt of the Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

The County may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

1) Required By Law

The County may use or disclose your protected health information to the extent that the use or disclosure is required by law. You will be notified, as required by law, of any such uses or disclosures.

2) Public Health

The County may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. The County may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3) Communicable Diseases

The County may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease.

4) Health Oversight

The County may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

5) Abuse or Neglect

The County may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, the County may disclose your protected health information if it believes that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

6) Food and Drug Administration

The County may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

7) Legal Proceedings

The County may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

8) Law Enforcement

The County may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on county premises, and (6) medical emergency (not on the county's premises) and it is likely that a crime has occurred.

9) Coroners, Funeral Directors, and Organ Donation

The County may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

10) Research

The County may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

11) Criminal Activity

Consistent with applicable federal and state laws, the County may disclose your protected health information, if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The County may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

12) Military Activity and National Security

When the appropriate conditions apply, the County may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. The County may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

13) Workers' Compensation

Your protected health information may be disclosed by the County as authorized to comply with workers' compensation laws and other similar legally-established programs.

14) Inmates

The County may use or disclose your protected health information if you are an inmate of a correctional facility and the County created or received your protected health information in the course of providing care to you.

15) Required Uses and Disclosures

Under the law, the County must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine County compliance with the requirements of 45 C.F.R. section 164.500 et. seq.

YOUR RIGHTS

The following are a list of your rights with respect to your protected health information and a brief description of how you may exercise these rights:

RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as the County maintains the protected health information. A "designated record set" contains medical and billing records and any other records that the County uses in making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact the County Privacy Contact if you have questions about access to your medical record.

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

This means you may ask the County not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The County is not required to agree to a restriction that you may request. If the County believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If the County does agree to the requested restriction, it may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with the County. You may request a restriction in writing to the County Privacy Officer.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS FROM THE COUNTY BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

The County will accommodate reasonable requests. The County may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. The County will not request an explanation from you as to the basis for the request. Please make this request in writing to the County Privacy Contact.

RIGHT TO REQUEST AN AMENDMENT TO YOUR PROTECTED HEALTH INFORMATION

This means you may request an amendment of protected health information about you in a designated record set for as long as the County maintains this information. In certain cases, the County may deny your request for an amendment. If the County denies your request for amendment, you have the right to file a statement of disagreement with the County and the County may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures the County may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice electronically.

COMPLAINTS

You may file a complaint to the County or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the County. You may file a complaint against the County by notifying the County Privacy Officer. The County will not retaliate against you for filing a complaint.

You may contact the County Privacy Officer, **[Insert Name of Privacy Contact]** at (____)____-____ or **[Insert e-mail address of Privacy Contact]** for further information about the complaint process.

This notice was published and becomes effective on **[complete with a date which should be no later than April 14, 2003]**.

**ACKNOWLEDGMENT OF
RECEIPT OF
NOTICE OF PRIVACY PRACTICE**

I, _____, do hereby
acknowledge receipt of a copy of the Notice of Privacy Practice, Policy and Procedure.

Signature of Individual

Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

Signature of personal representative

Date

Legal authority of personal representative

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

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

Client Name _____ ID # _____

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

Employee Signature

Date

- Certified Mail Return Receipt Attached