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| ***HIPAA Integrity*®** | **PR UDA 4.1.F** | **45 CFR 164.508(a)(1-2), (b), (c)** |
| **Exhibit**  Uses and Disclosures for Which an Authorization is Required – Authorizations for Uses and Disclosures—**Authorization Required: Psychotherapy Notes** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official if There are Any Questions Pertaining to Authorization for Use or Disclosure of Protected Health Information comprising Psychotherapy Notes*.** | | |
| **Individual Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designated Record Set # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Personal Representative**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Driver License # and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I hereby certify that I have the legal authority under applicable law to make this request on behalf of the individual named herein*.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Authorization**  I authorize the use or disclosure of the psychotherapy notes described below. I understand that the use or disclosure I am authorizing may result in the information being redisclosed by the recipient and no longer protected by the HIPAA Privacy Rule.  Purpose of Use or Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specific Description of Use or Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Person(s) Authorized to Make Use or Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Person(s) Authorized to Receive Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expiration of Authorization: \_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_ When the Following Event Occurs:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Signature**  I understand that I may revoke in a signed and dated written statement this authorization at any time, but my revocation is not effective until received by our organization’s Privacy Official at the address above. If I revoke this authorization, the revocation does not affect any actions taken by our organization or a business associate prior to receipt of the revocation. I also understand that I may refuse to sign this authorization, and that my refusal does not affect my treatment, enrollment in a health plan, or eligibility for benefits.  **Patient or Personal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Official Acknowledgement of Receipt of Authorization**  **Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Official Acknowledgement of Revocation of Authorization**  **Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

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| ***HIPAA Integrity*®** | **PR UDA 4.2.F** | **45 CFR 164.508(a)(1,3), (b), (c)** |
| **Exhibit**  Uses and Disclosures for Which an Authorization is Required – Authorizations for Uses and Disclosures—**Authorization Required: Marketing** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official if There are Any Questions Pertaining to Authorization for Use or Disclosure of Protected Health Information* related to *Marketing*.** | | |
| **Individual Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designated Record Set # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Personal Representative**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I hereby certify that I have the legal authority under applicable law to make this request on behalf of the individual named herein*.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**\_\_** Driver License # and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Marketing Communication**  Our organization periodically recommends products or services to individuals as members of the covered entity that may be of interest to them. When our organization provides promotional gifts of nominal value or recommends products or services in face-to-face communications, it does not require the member’s written authorization. Other kinds of marketing communications that we may recommend and for which we receive financial remuneration require written authorization prior to such communication. If you would like to receive information outlined in the authorization section below, please sign this form and return it to us at the facility address above at your convenience. | | |
| **Authorization**  I authorize the use or disclosure of my information described below. I understand that the use or disclosure I am authorizing may result in the information being redisclosed by the recipient and no longer protected by the HIPAA Privacy Rule. Describe Marketing Communication and Specific Member’s Protected Health Information Required for Communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Person(s) Authorized to Use or Make Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Person(s) Authorized to Receive Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expiration of Authorization: \_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_ Event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Signature**  I understand that I may revoke in a signed and dated written statement this authorization at any time, but my revocation is not effective until received by our organization’s Privacy Official at the address above. If I revoke this authorization, the revocation does not affect any actions taken by our organization or a business associate prior to receipt of the revocation. I also understand that I may refuse to sign this authorization, and that my refusal does not affect my treatment, enrollment in a health plan, or eligibility for benefits.  **Patient or Personal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Official Acknowledgement of Receipt of Authorization**  **Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Official Acknowledgement of Revocation of Authorization**  **Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

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| ***HIPAA Integrity*®** | **PR UDA 4.3.F** | **45 CFR 164.508(a)(1,4), (b), (c)** |
| **Exhibit**  Uses and Disclosures for Which an Authorization is Required – Authorizations for Uses and Disclosures—**Authorization Required: Sale of PHI** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official if There are Any Questions Pertaining to Authorization for Use or Disclosure of Protected Health Information Relating to the Sale of Protected Health Information*.** | | |
| **Individual Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designated Record Set # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Personal Representative**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Driver License # and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I hereby certify that I have the legal authority under applicable law to make this request on behalf of the individual named herein*.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Authorization**  I authorize the disclosure of the protected health information by sale described below, for which I understand that your organization will receive remuneration. I understand that the disclosure I am authorizing may result in the information being redisclosed by the recipient and no longer protected by the HIPAA Privacy Rule.  Purpose of Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specific Description of Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Person(s) Authorized to Make Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Person(s) Authorized to Receive Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expiration of Authorization: \_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_ When the Following Event Occurs:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Signature**  I understand that I may revoke in a signed and dated written statement this authorization at any time, but my revocation is not effective until received by your organization’s Privacy Official at the address above. If I revoke this authorization, I understand that the revocation does not affect any actions taken by your organization or a business associate prior to receipt of the revocation. I also understand that I may refuse to sign this authorization, and that my refusal does not affect my treatment, enrollment in a health plan, or eligibility for benefits.  **Patient or Personal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Official Acknowledgement of Receipt of Authorization**  **Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Official Acknowledgement of Revocation of Authorization**  **Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

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| ***HIPAA Integrity*®** | | | **PR UDA 6.1.F** | | | | **45 CFR 164.512(a)-(l)** | | |
| **Exhibit**  Uses and Disclosures for Which an Authorization or Opportunity to Agree or Object is not Required  **Use and Disclosure Log** | | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Use this log to document any use or disclosure for which an authorization or opportunity to agree or object is not required, including when it is required by *Standards* herein to inform the individual of a permitted use or disclosure, or when the individual may agree to a permitted use or disclosure and our organization’s information and the individual's agreement are given orally. | | | | | | | | | |
| **Individual’s Name & Designated Record Set #** | **Standard CFR #**  **And Use (U) or Disclosure (D)** | **Description of PHI to be**  **Used (U) Disclosed** | | **Date of Request for Use or Disclosure** | **Date of Response to Request for Use or Disclosure** | **Name of Recipient of Use or Disclosure** | | **Purpose of Use or Disclosure** | **Privacy Official Initials and Date** |
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| ***HIPAA Integrity*®** | **PR UDA 8.1.F** | **45 CFR 164.520** |
| **Exhibit**  Notice of Privacy Practices for Protected Health Information  **Acknowledgement of Receipt of Notice of Privacy Practices** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Our organization has provided you or your personal representative with our organization’s *Notice of Privacy Practices.* Our organization is making a good faith effort to have you acknowledge receipt by signing this form. You may refuse to acknowledge receipt by refusing to sign this acknowledgement, or we were unable to document signed acknowledgement for the appropriate reason noted. This form, after delivery of the *Notice of Privacy Practices*, will be signed by our organization’s Privacy Official and maintained according to the HIPAA Privacy Rule *Documentation* standard. | | |
| **Individual**  I acknowledge receipt of the *Notice of Privacy Practices* from <Name of Covered Entity or Business Associate>.  Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designated Record Set # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Privacy Official**  \_\_\_\_\_ Individual acknowledges receipt from another covered entity in our *organized health care arrangement*, if applicable.  \_\_\_\_\_ Individual refused to sign.  \_\_\_\_\_ Communication barrier prohibited obtain signature  \_\_\_\_\_ Not practicable to obtain acknowledgement because of emergency situation.  \_\_\_\_\_ Other (specify circumstance) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| ***HIPAA Integrity*®** | **PR UDA 9.1.F1** | **45 CFR 164.522(a)** |
| **Exhibit**  Rights to Request Privacy Protection for Protected Health Information  **Request for Restriction of Uses and Disclosures of PHI** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official if There are Any Questions Pertaining to Request for Restriction of Uses and Disclosures of Protected Health Information*** | | |
| This is a procedure of the *Right of an Individual to Request Restriction of Uses and Disclosures* standard of the *Rights to Request Privacy Protection for Protected Health Information* section at 45 CFR 164.522(a). | | |
| **Individual Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Personal Representative**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Driver License # and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient named herein*.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Request for Restriction of Use or Disclosure of PHI for Treatment, Payment, or Health Care Operations**  Use this section of this form if you want our organization to restrict use or disclosure of the individual’s protected health information (PHI) to carry out treatment, payment, or health care operations. Please specify exactly the PHI that you would like to have restricted. Under the HIPAA Privacy Rule, our organization is not required to agree to a request for restriction. Specify your request here: | | |
| **Request for Restriction When Individual Pays in Full**  Use this section if you want our organization to restrict disclosure of PHI about the individual to a health plan if the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full. Under the HIPAA Privacy Rule, our organization is required to agree to this restriction. Specify the health care item or service here: | | |
| **Signature**  **Patient or Personal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Official Approval of Request for Restriction**  **Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_** | | |

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| ***HIPAA Integrity*®** | **PR UDA 9.1.F2** | **45 CFR 164.522(a)** |
| **Exhibit**  Rights to Request Privacy Protection for Protected Health Information  **Terminating a Request for Restriction of Uses and Disclosures of PHI** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official if There are Any Questions Pertaining to Terminating a Restriction of the Request for Restriction of Uses and Disclosures of Protected Health Information*** | | |
| This is the *Terminating a Restriction*  procedure of the *Right of an Individual to Request Restriction of Uses and Disclosures* standard of the *Rights to Request Privacy Protection for Protected Health Information* section at 45 CFR 164.522(a)(2). | | |
| **Individual Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Personal Representative**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Driver License # and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient named herein*.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Request to Terminating a Restriction of Use or Disclosure of PHI**  I hereby request that your organization terminate the restrictions on the use and disclosure of protected health information that were agreed to by your organization’s Privacy Official on <date>, as shown on the attached copy of my original approved request to restrict use or disclosure of PHI for treatment, payment, or health care operations. I understand that this termination pertains only to protected health information created or received after our organization has informed you that it is terminating the restriction, as indicated by the date of the Privacy Official’s signature below.  **Attachment of Original Request for Restriction**  **\_\_\_\_ Initial:** Copy of Original Request for Restriction Attached | | |
| **Signature of Individual or Personal Representative to Request Termination of Restriction**  **Patient or Personal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Official Approval of Request for Termination of Restriction**  **Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_** | | |

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| ***HIPAA Integrity*®** | **PR UDA 9.2.F** | **45 CFR 164.522(b)** |
| **Exhibit**  Rights to Request Privacy Protection for Protected Health Information  **Request for Confidential Communications** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official if There are Any Questions Pertaining to Request for Confidential Communications in a Different Way or at a Different Place*** | | |
| This is a procedure the *Confidential Communications Requirements* standard of the *Rights to Request Privacy Protection for Protected Health Information* section at 45 CFR 164.522(b). | | |
| **Individual Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Personal Representative**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Driver License # and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient named herein*.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Request for Confidential Communications**  Use this form if you want our organization to communicate with you in a different way or at a different location than you have identified above. Please specify exactly the way you would like us to communicate with you, or at an address that you would like us to use, or both. You are not required to provide a reason for the request. | | |
| **Payment Information**  Your request for alternate communications means or location to use may impact our normal billing and payment receipt timing procedures. Please specify any alternative method for timely receipt of billing or provision of payment that may be affected by your request for confidential communications in a different way or location. | | |
| **Signature**  **Patient or Personal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Official Approval of Request for Confidential Communications**  **Privacy Official Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_** | | |

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| ***HIPAA Integrity*®** | **PR UDA 10.1.F** | **45 CFR 164.524(a)(1), (b), (c), (e)** |
| **Exhibit**  Access of Individuals to Protected Health Information—Access to PHI—  **Individual’s Request to Access Protected Health Information Records** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Privacy Official Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official if There are Any Questions Pertaining to Request to Access Records*** | | |
| This is a procedure of the *Requests for Access and Timely Action: Individuals Request for Access* implementation specification of the *Right of Access to Protected Health Information* standard at 45 CFR 164.524. | | |
| **Individual’s Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Personal Representative**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Individual \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Driver License # and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I hereby certify that I have the legal authority under applicable law to make this request on behalf of the individual.*  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Requested Records**  Initial: I want to \_\_\_\_\_ inspect, \_\_\_\_\_ obtain a copy, or \_\_\_\_\_ inspect and obtain a copy of requested records.  If a copy of the records: \_\_\_\_\_ Paper or \_\_\_\_\_ Electronic (if records are in electronic designated record set).  Describe in Detail and Approximate Date(s) or Date Range of Requested Records: | | |
| **Fee**  The HIPAA Privacy Rule at 45 CFR 164.524(c)(4) permits us to charge a reasonable, cost-based fee to copy records or prepare a summary or explanation of requested records, and mail the requested documentation to you. Please contact our Privacy Official for the estimated fee for the information you are requesting. | | |
| **Designated Contact**  Identify the Person Who Should Be Contacted Regarding This Request to Access Records:  **Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Means of Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Signature**  **Patient or Personal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| ***HIPAA Integrity*®** | **PR UDA 10.2.F1** | **45 CFR 164.524(a)(2-4), (d), (e)** |
| **Exhibit**  Amendment of Protected Health Information—Right to Amend--  **Response to Request for Access to Records** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_  Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Privacy Official Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| This is a procedure of the *Documentation* implementation specification of the *Right of Access to Protected Health Information* standard at 45 CFR 164.524. | | |
| **Individual’s Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Designated Record Set # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Access Request Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Acceptance of Request for Access to Records**  Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Individual)  Access \_\_\_\_\_\_ Granted.  Our organization grants you access to the records requested. Please contact our Privacy Official to arrange a convenient time for you or your personal representative if so noted in your request to inspect and to receive a copy your requested records. You also may request that we send your requested information to you through the US Postal Service. Our organization is permitted by the HIPAA Privacy Rule to charge a reasonable, cost-based fee to copy records or prepare a summary or explanation of requested records, if you agreed to a summary or explanation in advance, and mail the requested documentation to you. When you contact our Privacy Official, you may request an estimate of the fee for the information you are requesting and the manner of its receipt by you. | | |
| **Denial of Request for Access to Records**  Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Individual)  Access \_\_\_ Unreviewable Denial by Law \_\_\_ Reviewable Denial by Law \_\_\_ Partial Grant, Partially Denial  Our organization denies your request for access to records in whole or in part for the following reasons:  If denial is *reviewable*, you may request that our organization have the denial reviewed by a licensed health care professional who did not participate in the decision to deny access. If our decision is *partial grant, partial denial*, you also may request the aforementioned review if that denial is *reviewable*. To request a review, or to arrange to access records under a *partial grant* of access, or both, please contact our Privacy Official. | | |
| **Signature**  **Privacy Official Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

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| ***HIPAA Integrity*®** | | | **PR UDA 10.2.F2** | | | | **45 CFR 164.524(a)(2-4), (d)** | | |
| **Exhibit**  Amendment of Protected Health Information—Right to Amend--  **Response to Access of Records Log** | | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| This is a procedure of the *Documentation* implementation specification of the *Right of Access to Protected Health Information* standard at 45 CFR 164.524. | | | | | | | | | |
| **Patient Name** | **Designated Record Set #** | **Date of Records Access Request** | | **Date of Response to Access Request** | **Request Granted (G) or Denied (D)** | **Reason for Denial** | | **Denial Review Invoked by Requester:**  **Yes (Y)**  **No (N)** | **Privacy Official Initials and Date** |
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| ***HIPAA Integrity*®** | **PR UDA 11.1.F** | **45 CFR 164.526(a)(1), (b), (e), (f)** |
| **Exhibit**  Amendment of Protected Health Information—Right to Amend--  **Request to Amend Records** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official if There are Any Questions Pertaining to Request to Amend Records*** | | |
| This is a procedure the *Right to Amend* standard of the Amendment of Protected Health Information section at 45 CFR 164.526(a)(1). | | |
| **Patient Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Personal Representative**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Driver License # and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient named herein*.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Requested Record Amendment**  **Describe in Detail How and the Reason for Your Request to Amend Your Records in the Designated Record Set in Our Custody** | | |
| **Designated Contact**  Identify the Person Who Should be Contacted Regarding This Request to Amend Records:  **Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Means of Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Signature**  **Patient or Personal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

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| ***HIPAA Integrity*®** | **PR UDA 11.2.F1** | **45 CFR 164.526(c), (d), (e), (f)** |
| **Exhibit**  Amendment of Protected Health Information—Right to Amend--  **Response to Request to Amend Records: Denying or Accepting the Request** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official for Any Questions Regarding Our Response to Your Request to Amend Records*.** | | |
| This is a procedure the *Right to Amend* standard of the Amendment of Protected Health Information section at 45 CFR 164.526(a)(2). | | |
| **Patient Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Designated Record Set # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Amendment Request \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Personal Representative (if designated in Request) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Designated Address in Request for Delivery of Response \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Response to Request to Amend Records**  Action: Granted \_\_\_ Denied \_\_\_ Partially Granted \_\_\_  If Granted, the following amendment was made to your records in the designated record set:  If Denied, the denial for your amendment request is for the following specific reasons:  \_\_\_ The protected health information was not created by our organization.  \_\_\_ The protected health information is not part of the designated record set in our custody.  \_\_\_ The protected health information is not available for inspection under the HIPAA Privacy Rule.  \_\_\_ The protected health information is accurate and complete.  You have a right to submit a written statement to our Privacy Official disagreeing with our denial of your request for amendment of your records in our designated record set. You also have a right to submit a complaint concerning the denial to our Privacy Official, to the Secretary of the Department of Health and Human Services (HHS) within 180 days of any alleged violation, or to both. Your complaint must describe the acts or omissions that you believe are in violation of the HIPAA Privacy Rule regarding this matter.  Please contact me if you have any questions regarding our response to your request for amendment of your records.  Sincerely,  <Privacy Official Name> Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| ***HIPAA Integrity*®** | | | **PR UDA 11.2.F2** | | | **45 CFR 164.526(a)-(f)** | | |
| **Exhibit**  Amendment of Protected Health Information—Right to Amend--  **Amendment Request and Disposition Log** | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| This is a procedure the *Right to Amend* standard of the Amendment of Protected Health Information section at 45 CFR 164.526(f) and 45 CFR 164.530(j)(1) at PR, AR10.1: the HIPPA Privacy Rule *Documentation* standard. | | | | | | | | |
| Patient Name | Date of Amendment Request | Amendment Requested | | Request Amendment Approved (A) or Denied (D) and Date | Date Approved Amendment Completed | | Identity of Third Parties Notified of Approved Amendment | Date Amendment Notification Sent to Third Parties |
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| ***HIPAA Integrity*®** | **PR UDA 12.1.F** | **45 CFR 164.528(a)** |
| **Exhibit**  Accounting of Disclosures of Protected Health Information—Right to an Accounting of Disclosures of PHI—**Request for Accounting of Disclosures** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_  ***Please Contact Our Privacy Official if There are Any Questions Pertaining to Request to Amend Records*** | | |
| This is a procedure related to the *Right to an Accounting of Disclosures of PHI* standard at 45 CFR 164.528(a). | | |
| **Patient Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Requested Accounting of Disclosures**  This document is a request for an accounting of disclosures made of the protected health information of the patient pursuant to the right of the patient for such accounting under the HIPAA Privacy Rule at 45 CFR 164.528(a) for the following time period up to or within six years from the date of this request:  Time Period Requested: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Certain Types of Disclosures \_\_\_\_\_\_\_\_ Explain Scope Here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Disclosures to a Specific Entity \_\_\_\_\_\_\_ Identify Entity Here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Note**. Please see accompanying policy that identifies exceptions for which our organization is not required to provide an accounting of disclosures made. | | |
| **Personal Representative**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Driver License # and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient named herein*.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Designated Contact**  Identify the Person Who Should Be Contacted Regarding This Request for Accounting of Disclosures:  **Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Means of Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Signature for and Date of Request**  **Patient or Personal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

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| ***HIPAA Integrity*®** | | **PR UDA 12.2.F1** | | **45 CFR 164.528(b), (c), (d)** | |
| **Exhibit**  Accounting of Disclosures of Protected Health Information—Right to an Accounting of Disclosures of PHI—**Response to Request for Accounting of Disclosures** | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| This is a procedure related to the *Content of the Accounting* implementation specification of the *Right to an Accounting of Disclosures of PHI* standard at 45 CFR 164.528(a). | | | | | |
| **Patient Information**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Designated Record Set # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Request \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Response**  This document responds to your request for an accounting of disclosures of protected health information from your designated record set during the timeframe you specified. The following includes all of the disclosures that we are required to provide you according to the HIPAA Privacy Rule and our policies.  Time Period Requested: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Disclosures** | | | | | |
| **Date of the Disclosure** | **Name, Type, and Address of Entity Receiving Disclosure** | | **Description of Protected Health Information Disclosed** | | **Purpose of the Disclosure** |
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| **Privacy Official**  Please contact me if you have any questions regarding this response to your request.  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

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| ***HIPAA Integrity*®** | | | **PR UDA 12.2.F2** | | | | **45 CFR 164.528(b), (c), (d)** | | |
| **Exhibit**  Accounting of Disclosures of Protected Health Information—Right to an Accounting of Disclosures of PHI—**Response to Accounting of Disclosures Log** | | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| This is a procedure related to the *Content of the Accounting, Provision of the Accounting,* and *Documentation* implementation specifications of the *Right to an Accounting of Disclosures of PHI* standard at 45 CFR 164.528(a). | | | | | | | | | |
| **Log** | | | | | | | | | |
| **Patient Name** | **Designated Record Set #** | **Person or Entity Receiving Disclosure** | | **Description of PHI Disclosed** | **Purpose of Disclosure** | **Was Research Purpose of Disclosure** | | **Was this a Multiple Disclosure to Same Person or Entity** | **Name, Title, and Signature of Privacy Official or Other Responsible Party or Office Processing Request and Response** |
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| ***HIPAA Integrity*®** | | **PR, AR.4.1.F1** | | **45 CFR 164.530(d)** | |
| **Exhibit**  Administrative Requirements  **Complaints to the Covered Entity: Documentation of Complaints: Complaint Log** | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Instructions**  This complaint log is to track an individual’s complaint concerning the covered entity’s policies and procedures required by the HIPAA Privacy Rule or HITECH Act Breach Notification Rule or its compliance with such policies and procedures or requirements of those Rules. The Privacy Official is responsible for maintaining this log and keeping it current. | | | | | |
| **Individual Filing a Privacy Complaint** | **Description of the Complaint** | **Date Complaint Filed with Covered Entity** | **Person at Covered Entity Who Received the Complaint** | **Privacy Official’s Actions by Date, and Initials** | **Privacy Official’s Resolution by Date, and Initials** |
| *Name, Address, Email, Telephone* |  | *yyyy/mm/dd* | *Name* | *Narrative and yyyy/mm/dd* | *Narrative and yyyy/mm/dd* |
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| ***HIPAA Integrity*®** | **PR, AR.4.1.F2** | **45 CFR 164.530(d)** |
| **Exhibit**  Administrative Requirements  **Complaints to the Covered Entity: Documentation of Complaints: Complaint Form** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Instructions**  This complaint form is used by our organization for receipt and management of a complaint from an individual concerning the covered entity’s policies and procedures required by the HIPAA Privacy Rule or HITECH Act Breach Notification Rule or its compliance with such policies and procedures or requirements of those Rules. When completed and the complaint is resolved, a copy of this form will be made a part of the individual’s *designated record set*. The Privacy Official is responsible for maintaining a file of completed forms and designating a file name in the complaint log resolution narrative. | | |
| **Complainant**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Description of Complaint and Date of Complaint**  Description\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Signature of Complainant**  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Action Requested by Complainant**  Contact Me for Follow-up by \_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_ Mail  Do not Contact Me for Follow-up \_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_ Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Person Receiving Complaint in Covered Entity and Date of Receipt**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Receipt \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Date Recipient Gave Complaint Form to Privacy Official**  Date of Delivery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Privacy Officials Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Date of Follow-up with Complainant**  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_ Mail \_\_\_\_ Both Telephone and Mail \_\_\_\_  Resolution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Privacy Officials Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| ***HIPAA Integrity*®** | | | **SR, AS 1.2.F** | | | **45 CFR 164.308(a)(1)(ii)(B)** | |
| **Exhibit**  Administrative Safeguards  **Security Management Process: Risk Management**  **Risk Analysis Report Log** | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Instructions**  This is a procedure under the required *Risk Management* implementation specification of the Administrative Safeguard standard: Security Management Process, at 45 CFR 164.308(a)(1)(i). All documentation pertaining to conducting or reviewing a Risk Analysis must be retained for six years from the last action as required by the HIPAA Security Rule Documentation standard, at 45 CFR 164.316(b)(2)(i). The Security Official should assign a *riskanalysis1yyyymmdd-1*.docx filename for the original risk analysis, where yyyymmdd is the date conducted and date approved, respectively; and assign *riskanalysis1yyyymmdd-n*.docx filename for a review of the original risk analysis, where yyyymmdd is the date reviewed and date approved, respectively and “-n” represents the review number in sequence, starting with “-1”. If a risk analysis is conducted anew, assign *riskanalysis2yyyymmdd*.docx, and so on, as discussed immediately above. | | | | | | | |
| **Risk Analysis** | **Date Conducted** | **Date Approved** | | **Date Reviewed** | **Date Approved** | | **Security Official Initials and Date** |
| *Filename* | *yyyy/mm/dd* | *yyyy/mm/dd* | | *yyyy/mm/dd* | *yyyy/mm/dd* | |  |
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| ***HIPAA Integrity*®** | **SR, AS 1.3.F** | **45 CFR 164.308(a)(1)(ii)(C)** |
| **Exhibit**  Administrative Safeguards  **Security Management Process—Sanction Policy**  **Workforce Member Sanctions Policy Acknowledgement** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Acknowledgement of Workforce Member**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the *Sanction Policy* implementation specification policy and procedures of the Administrative Safeguard *Security Management Process* standard in our organization’s set of HIPAA Security Rule Safeguard Policies and Procedures. I understand that I am subject to imposition of our organization’s sanctions regarding impermissible access, use, or disclosure of protected health information that violates the authorization granted to me. I further understand that any questions or issues concerning safeguarding of protected health information in our organization should be addressed to our organization’s Privacy Official or Security Official, as appropriate, for guidance.  Signature of Workforce Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Security Official \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| ***HIPAA Integrity*®** | | | **SR, AS 2.0.F** | | | **45 CFR 164.308(a)(2)** | | |
| **Exhibit**  Administrative Safeguards  **Assigned Security Responsibility**  **Security Safeguard Complaint Log** | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Instructions**  The Security Official is responsible for “development and implementation of the policies and procedures required by [the HIPAA Security Rule] for the covered entity or business associate.” 45 CFR 164.308(a)(2) Any complaint regarding security safeguards should be referred to the Security Official. This log, which is to be maintained by the Security Official, is designed to track HIPAA Security Rule complaints and the manner in which they were mitigated. The Security Official should assign a *complainantnameyyyymmdd*.docx filename for notation in the log, where *yyyymmdd* is the Date Complaint Received. The noted file should contain a Description of the Complaint, and the Security Official’s Written Response to the Complainant and the Date of such Response. | | | | | | | | |
| **Security**  **Complaint Description** | **Complainant** | **Complaint Presented to Workforce Member** | | **Date Complaint Received** | **Security Official’s Action** | | **Security Official’s Response to Complainant and Date** | **Security Official Initials** |
| *Filename* | *Name, Address,*  *Email, Telephone* | *Name* | | *yyyy/mm/dd* | *Filename* | | *yyyy/mm/dd* |  |
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| ***HIPAA Integrity*®** | **SR, AS 3.1.F1** | **45 CFR 164.308(a)(3)(ii)(A)** |
| **Exhibit**  Administrative Safeguards  **Workforce Security: Authorization and/or Supervision**  **Workforce Member Authorization Acknowledgement** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Acknowledgement of Workforce Member**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the *Authorization and/or Supervision* implementation specification policy and procedures of the Administrative Safeguard *Workforce Security* standard in our organization’s set of HIPAA Security Rule Safeguard Policies and Procedures. I understand that my job description and responsibilities therein grant me clearance to access an individual’s protected health information (PHI) in electronic or hard copy form. I also have read the *Sanction Policy* implementation specification policy and procedures of the Administrative Safeguard *Security Management Process* standard in our organization’s set of HIPAA Security Rule Safeguard Policies and Procedures. I understand that I am subject to imposition of our organization’s sanctions regarding impermissible access, use, or disclosure of protected health information that violates the authorization granted to me.  I further understand that any questions or issues concerning safeguarding of protected health information in our organization should be addressed to our organization’s Privacy Official or Security Official for guidance.  Signature of Workforce Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Security Official \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| ***HIPAA Integrity*®** | | | **SR, AS 3.1.F2** | | | **45 CFR 164.308(a)(3)(ii)(A)** | | |
| **Exhibit**  Administrative Safeguards  **Workforce Security: Authorization and/or Supervision**  **Stationary Hardware Assignment and Encryption Log** | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| This is a procedure that ties in with workforce member authorization to access electronic protected health information, generally on a particular stationary workstation, device, or media in a facility. It also is germane to other policies and procedures, namely, the addressable *Accountability* implementation specification of the Physical Safeguard standard: Device and Media Controls (45 CFR 164.310(d)(2)(iii) at SR, PS.4.3); the addressable *Encryption and Decryption* implementation specification of the Technical Safeguard standard: Access Control (45 CFR 164.312(a)(2)(iv) at SR, TS.1.4); and the addressable *Encryption* implementation specification of the Technical Safeguard standard: Transmission Security (45 CFR 164.312(e)(2)(ii) at SR, TS.5.2). | | | | | | | | |
| **Type of Stationary**  **Hardware** | **Assigned Workforce Member User** | **Date Stationary Hardware Assigned** | | **Date Stationary**  **Hardware Returned** | **Date**  ***Data at Rest* Encryption**  **Verified** | | **Date**  ***Data in Motion* Encryption**  **Verified** | **Security Official Initials and Date** |
| *Name*  *ID#* | *Name, Facility Address,*  *Email, Telephone* | *yyyy/mm/dd* | | *yyyy/mm/dd* | *yyyy/mm/dd* | | *yyyy/mm/dd* |  |
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| ***HIPAA Integrity*®** | | | **SR, AS 3.2.F** | | | **45 CFR 164.308(a)(3)(ii)(B)** | | |
| **Exhibit**  Administrative Safeguards  **Workforce Security: Workforce Clearance Procedure**  **Workforce Member Background Check Log** | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| This is a procedure under the addressable Workforce Clearance Procedure implementation specification of the Administrative Safeguard standard: Workforce Security at 45 CFR 164.308(a)(3). | | | | | | | | |
| **Workforce Member Name and Status**  **N: New**  **E: Existing** | **Qualification & References**  **Check**  **Completed** | **Education**  **Check**  **Completed** | | **Financial**  **Check**  **Completed** | **Previous Employment**  **Check**  **Completed** | | **Criminal Record Check**  **Completed** | **Security Official Initials & Date** |
| *Name*  *Status* | *yyyy/mm/dd* | *yyyy/mm/dd* | | *yyyy/mm/dd* | *yyyy/mm/dd* | | *yyyy/mm/dd* |  |
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| ***HIPAA Integrity*®** | **SR, AS 3.3.F1** | **45 CFR 164.308(a)(3)(ii)(C)** |
| **Exhibit**  Administrative Safeguards  **Workforce Security: Termination Procedures**  **Workforce Member Exit Checklist** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| This is a procedure under the addressable Termination Procedures implementation specification of the Administrative Safeguard standard: Workforce Security at 45 CFR 164.308(a)(3). | | |
| Workforce Member Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_  Departure Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Security Actions**  \_\_\_\_\_\_ Disable immediately all user authorizations (e.g., IDs and passwords, biometric, if applicable) for access to the organization’s electronic networks, systems, applications, devices, and media that contain electronic protected health information *and* proprietary business records.  \_\_\_\_\_\_ Disable access to the organization’s hosted email and email server.  \_\_\_\_\_\_ Disable access to organization voice mail.  \_\_\_\_\_\_ Retrieve organization credit cards and cancel any online purchasing authorization(s).  \_\_\_\_\_\_ Retrieve mobile and portable electronic devices (e.g., phone, tablet, laptop, notebook).  \_\_\_\_\_\_ Retrieve keys, keycards, and other organization-provided access tokens or devices.  \_\_\_\_\_\_ Retrieve hard copy organization handbook(s), and proprietary documents and work products.  **Human Resource Actions**  \_\_\_\_\_\_ Letter of resignation received; or Notice of termination delivered.  \_\_\_\_\_\_ Final timesheet or activity report(s) delivered.  \_\_\_\_\_\_ Workforce member address on file for delivery of final compensation.  \_\_\_\_\_\_ Discussion with workforce member on disposition of benefits (e.g., health insurance, retirement contributions, and personal, vacation, and sick leave, as applicable)  Signature of Security Official \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Note:** When completed, Exhibit 1 should be appended to Exhibit 2, the signed *Workforce Member Exit Interview* *Acknowledgement* (SR, AS.3.3F2 and placed in the terminated workforce member’s personnel file. | | |

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| ***HIPAA Integrity*®** | **SR, AS 3.3.F2** | **45 CFR 164.308(a)(3)(ii)(C)** |
| **Exhibit**  Administrative Safeguards  **Workforce Security: Termination Procedures**  **Workforce Member Exit Interview Acknowledgement** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| This is a procedure under the addressable Termination Procedures implementation specification of the Administrative Safeguard standard: Workforce Security at 45 CFR 164.308(a)(3). | | |
| **Acknowledgement of Workforce Member**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that in ending my relationship as a working force member, whether voluntarily or involuntarily, that I acknowledge my awareness and understanding of the following, and so indicate by my initials in the spaces provided:  \_\_\_\_\_\_\_ My access to electronic protected health information is terminated and all authentication and authorization credentials for access are invalidated and, as appropriate, removed from networks, systems, applications, devices, and media.  \_\_\_\_\_\_\_ Keys, keycards, and other organization-provided access tokens or devices have been returned, and biometric access, if applicable, has been cancelled.  \_\_\_\_\_\_\_ All electronic devices and media, and all proprietary files and materials, have been returned to this organization.  \_\_\_\_\_\_\_ This organization shall refer any unauthorized attempts at access to its networks, systems, applications, devices, or media to the appropriate authorities.  \_\_\_\_\_\_\_ A representative of this organization has completed this exit interview and I have provided physical and email addresses, and a telephone contact number for any necessary follow-up.  Physical Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Workforce Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Security Official \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Note:** When completed, Exhibit 1 (SR, AS.3.3F1) *Workforce Member Exit Checklist* should be appended to this signed Form and placed in the terminated workforce member’s personnel file. | | |

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| ***HIPAA Integrity*®** | **SR, AS 4.3.F1** | **45 CFR 164.308(a)(4)(ii)(C)** |
| **Exhibit**  Administrative Safeguards  **Information Access Management: Access Establishment and Modification**  **Workforce Member Right of Access Authorization Modification Acknowledgement** | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| This is a procedure under the addressable Access Establishment and Modification implementation specification of the Administrative Safeguard standard: Information Access Management at 45 CFR 164.308(a)(4). | | |
| **Acknowledgement of Workforce Member**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the  *Authorization and/or Supervision* implementation specification policy and procedures of the Administrative Safeguard *Workforce Security* standard in our organization’s set of HIPAA Security Rule Safeguard Policies and Procedures. I understand that my job description and responsibilities have changed and that my right of access authorization to an individual’s protected health information (PHI) in electronic or hard copy form has been modified as described on the effective date below. I also have read the *Sanction Policy* implementation specification policy and procedures of the Administrative Safeguard *Security Management Process* standard in our organization’s set of HIPAA Security Rule Safeguard Policies and Procedures. I understand that I am subject to imposition of our organization’s sanctions regarding impermissible access, use, or disclosure of protected health information that violates the authorization granted to me.  I further understand that any questions or issues concerning safeguarding of protected health information in our organization should be addressed to our organization’s Privacy Official or Security Official for guidance.  Description of the Right of Access Authorization Modification:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Workforce Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Security Official \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| ***HIPAA Integrity*®** | | **SR, AS 4.3.F2** | | | **45 CFR 164.308(a)(4)(ii)(C)** | |
| **Exhibit**  Administrative Safeguards  **Information Access Management: Access Establishment and Modification**  **Workforce Member Right of Access Authorization Modification Log** | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| This is a procedure under the addressable Access Establishment and Modification implementation specification of the Administrative Safeguard standard: Information Access Management at 45 CFR 164.308(a)(4). | | | | | | |
| **Workforce Member** | **Reason for Access Modification** | | **Description of Access Modification** | **Effective Date of Access Modification** | | **Security Official Initials & Date** |
| *Name* |  | |  | *yyyy/mm/dd* | |  |
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| ***HIPAA Integrity*®** | | | **SR, AS 5.0.F** | | | **45 CFR 164.308(a)(5)(i)** | | |
| **Exhibit**  Administrative Safeguards  **Security Awareness and Training**  **Security Safeguard Training for Workforce Members Log** | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| This is a procedure under the HIPAA Security Rule *Security Awareness and Training* standard that requires that a covered entity or business associate “implement a security awareness and training program for all members of its workforce (including management).” 45 CFR 164.308(a)(5) Unlike HIPAA Privacy Rule training (see PR, AR.2.1*)*, which covers safeguarding protected health information in oral, electronic, or hard copy forms, HIPAA Security Rule training only covers safeguarding *electronic* protected health information.  Associate a filename [*securityyyyymmddnameoftrainer*.docx] with each *Name of Trainer* that describes the Trainer’s Company affiliation and Website URL if training is in person, or with the Name of Website [URL] if training is provided online; include within the associated filename a description of topics covered in the training, hours of training, whether Trainee was tested on “awareness and understanding” of the training course material, and test results, if applicable. | | | | | | | | |
| **Workforce Member Trainee Name and Status**  **N: New**  **E: Existing** | **Date(s) of Training** | **Trainer** | | **Training Course Filename** | **Signature of Trainer** | | **Signature of Trainee** | **Security Official Initials and Date** |
| *Name*  *Status* | *yyyy/mm/dd* | *Name* | | *Filename* |  | |  |  |
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| ***HIPAA Integrity*®** | | | **SR, AS 6.1.F** | | | **45 CFR 164.308(a)(6)(ii)** | | |
| **Exhibit**  Administrative Safeguards  **Security Incident Procedures: Response and Reporting**  **Security Incident Report Log** | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| This is a procedure under the required Response and Reporting implementation specification of the Administrative Safeguard standard: Security Incident Procedures. 45 CFR 164.308(a)(6)(i) In addition, the information required to document a security incident is available online at the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services on the Web site entitled *Submitting Notice of a Breach to the Secretary*, which can be accessed at: <http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html>.  If a discovered Security Incident affects 500 or more individuals, a report form at that URL must be submitted to HHS within 60 days and coincident with notification to affected individuals (see 45 CFR 164.408(b) (*Notification to the Secretary*) at BN, N.3.1). If fewer than 500 individuals are affected, the covered entity must maintain a log, and report that and similar incidents in a calendar year within 60 days of the close of that calendar year (see 45 CFR 164.408(c) (*Notification to the Secretary*) at BN, N.3.2). Report all Security Incidents in this log.  The Security Official should assign a *descriptoryyyymmdd*.docx filename for notation in the log, where *yyyymmdd* is the Date of Discovery of Security Incident. The noted file should contain the *Security Incident Report*: a Description of the Discovered Security Incident, Date of Discovery, Whether Covered Entity or Business Associate was Involved, Location of the Security Incident, Whether Electronic Protected Health Information was Accessed, Used, or Disclosed, Date of and How Security Incident was Mitigated, including any Changes to Policies and Procedures, Number of Impacted Individuals, and Whether Appropriate Breach Notifications Were Required. | | | | | | | | |
| **Date of Discovery, Filename for, and Brief Description of Discovered Security Incident** | **Location of Security Incident**  **CE**: Covered Entity  **BA**: Business Associate | **Was Electronic Protected Health Information Impermissibly Accessed, Used, or Disclosed?** | | **Date of Mitigation of Security Incident?** | **Number of Impacted Individuals** | | **Were Appropriate Breach Notifications**  **Required?** | **Security Official Initials and Date** |
| *yyyy/mm/dd*  *Filename* | *Code* | *Yes or No* | | *yyyy/mm/dd* | *#* | | *Yes or No* |  |
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| ***HIPAA Integrity*®** | | | **SR, PS 1.4.F** | | | **45 CFR 164.310(a)(2)(iv)** | |
| **Exhibit**  Physical Safeguards  **Facility Access Controls: Maintenance Records**  **Maintenance Record Log** | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Instructions**  This is a procedure under the Maintenance Records implementation specification of the Physical Safeguard standard: Facility Access Controls (45 CFR 164.310(a)(2)(iv)). Maintain a log of repairs or modifications to your facility’s physical security components, including hardware, walls, doors, and locks. The Security Official should assign a *descriptoryyyymmdd*.docx filename for notation in the log, where *yyyymmdd* is the Date of Maintenance Completed. The noted file should contain a Description of the Maintenance, the Party Responsible for Conducting Maintenance, and a scanned copy of the Invoice for the Completed Maintenance. | | | | | | | |
| **Description of Maintenance** | **Date Maintenance Scheduled** | **Date Maintenance Completed** | | **Party Responsible for Conducting**  **Maintenance** | **Cost of Maintenance** | | **Security Official Initials and Date** |
| *Filename* | *yyyy/mm/dd* | *yyyy/mm/dd* | | *Name, address, email, phone* | *Filename* | | *yyyy/mm/dd* |
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| ***HIPAA Integrity*®** | | | **SR, PS 4.1.F** | | | | **45 CFR 164.310(d)(2)(i)** | | |
| **Exhibit**  Physical Safeguards  **Device and Media Controls: Disposal**  **Log for Disposal of Hard Copy and Electronic Media Containing Protected Health Information** | | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **Instructions**  The Security Official is responsible for ensuring that disposal of hard copy and electronic media containing protected health information (PHI) is appropriately executed, tested, and verified. The Security Official should maintain an electronic log of disposals, using a *descriptoryyyymmdd*.docx filename for each notation in the log, where *yyyymmdd* is the Date disposal was completed. The file should contain a description of the Disposal Method used for each disposal entry, the workforce member responsible for executing, testing, and verifying the disposal, and a scanned copy of the invoice for the disposal if conducted by an outside vendor. | | | | | | | | | |
| **Type of Media**  **Containing PHI:**  **H: Hard Copy**  **E: Electronic** | **Description**  **If H: Name & Designated Record Set #;**  **If E: Name, Model, and Serial #** | **Responsible Workforce Member for Disposal of Media Containing PHI** | | **Was OCR’s *Guidance* Consulted for Disposal Method**  **Y: Yes**  **N: No** | **Was NIST’s *Guidelines for Media Sanitation* Consulted for Disposal Method**  **Y: Yes**  **N: No** | **Description of Disposal Method** | | **Date**  **Disposal Method Executed, Tested, and Verified** | **Security Official Initials and Date** |
| *Code* | *Name & ID#* | *Name, email, phone* | | *Y or N* | *Y or N* | *Text* | | *yyyy/mm/dd* | *yyyy/mm/dd* |
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| ***HIPAA Integrity*®** | | | **SR, PS 4.2.F** | | | | **45 CFR 164.310(d)(2)(ii)** | | |
| **Exhibit**  Physical Safeguards  **Device and Media Controls: Media Re-use**  **Log for Removal of Electronic Protected Health Information on Electronic Media Before Re-use** | | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **Instructions**  The Security Official is responsible for ensuring that removal of electronic protected health information (ePHI) on electronic media before re-use is appropriately executed, tested, and verified. The Security Official should maintain an electronic log of this action, using a *descriptoryyyymmdd*.docx filename for each notation in the log, where *yyyymmdd* is the Date the action was completed. The file should contain a description of the action for each re-use of electronic media, the workforce member responsible for executing, testing, and verifying the removal of ePHI, and a scanned copy of the invoice for the action if conducted by an outside vendor. | | | | | | | | | |
| **Describe Type of Electronic Media**  **Containing ePHI** | **Name, Model, and Serial # of the Electronic Media** | **Workforce Member Responsible for ePHI Removal from Designated Electronic Media** | | **Was OCR’s *Guidance* Consulted for ePHI Removal from Electronic Media**  **Y: Yes**  **N: No** | **Was NIST’s *Guidelines for Media Sanitation* Consulted for ePHI Removal Method**  **Y: Yes**  **N: No** | **Description of ePHI Removal Method** | | **Date**  **ePHI Removal Method Executed, Tested, and Verified** | **Security Official Initials and Date** |
| *Text* | *Name & ID#* | *Name, email, phone* | | *Y or N* | *Y or N* | *Text* | | *yyyy/mm/dd* | *yyyy/mm/dd* |
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| ***HIPAA Integrity*®** | | | | **SR, PS 4.3.F1** | | | | **45 CFR 164.310(d)(2)(iii)** | | |
| **Exhibit 1**  Physical Safeguards  **Device and Media Controls: Accountability**  **Log of Movements of Stationary Information Systems and Electronic Media** | | | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Instructions**  This log covers procedures under the *Accountability* implementation specification (45 CFR 164.310(d)(2)(iii) and the *Data Backup and Storage* implementation specification (45 CFR 164.310(d)(2)(iv) at SR, PS.4.4) of the Physical Safeguard standard: *Device and Media Controls* (45 CFR 164.310(d)(1) at SR, PS.4.0). | | | | | | | | | | |
| **Type of Hardware** | **Hardware Identifier** | **Old Location**  **Address** | **New Location Address** | | **Assigned Workforce Member User** | **Reassigned Workforce Member (if applicable)** | **Exact Copy of ePHI Retrieved prior to Movement:**  **Yes or No** | | **Date Hardware Moved (M) or Taken Out of Service (X)** | **Security Official Initials and Date** |
| *Name* | *ID#* |  |  | | *Name, Facility Address, Email, Telephone* | *Name, Facility Address, Email, Telephone* | *Yes or No* | | *yyyy/mm/dd*  *Code:*  *(M) or (X)* | *yyyy/mm/dd* |
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| ***HIPAA Integrity*®** | | | **SR, PS 4.3.F2** | | | | **45 CFR 164.310(d)(2)(iii)** | | |
| **Exhibit 2**  Physical Safeguards  **Device and Media Controls: Accountability**  **Log of Use of Portable Electronic Media Outside of the Facility—Assignment and Encryption** | | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **Instructions**  This is a procedure that focuses on the use of portable electronic media such as mobile devices (e.g., smartphones and tablets), laptop and similar devices, and storage devices containing electronic protected health information (ePHI) outside of the facility. Information here falls under multiple implementation specifications: the addressable *Accountability* implementation specification of the Physical Safeguard standard: Device and Media Controls (45 CFR 164.310(d)(2)(iii)); the addressable *Encryption and Decryption* implementation specification of the Technical Safeguard standard: Access Control (45 CFR 164.312(a)(2)(iv))—see ***HIPAA Integrity*®** SR, TS.1.4.F; and the addressable *Encryption* implementation specification of the Technical Safeguard standard: Transmission Security (45 CFR 164.312(e)(2)(ii))—see ***HIPAA Integrity*®** SR, TS.5.2.F. | | | | | | | | | |
| **Type of Portable**  **Electronic Media** | **Portable Electronic Media Identifier** | **Assigned Workforce Member User** | | **Date**  **Portable Electronic Media Assigned** | **Date Portable**  **Electronic Media Returned** | **Date**  ***Data at Rest* Encryption**  **Verified** | | **Date**  ***Data in Motion Encryption***  ***Verified*** | **Security Official Initials and Date** |
| *Name* | *ID#* | *Name, Facility Address, Email, Telephone* | | *yyyy/mm/dd* | *yyyy/mm/dd* | *yyyy/mm/dd* | | *yyyy/mm/dd* |  |
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| ***HIPAA Integrity*®** | | **SR, TS 1.2.F** | | | | **45 CFR 164.312(a)(2)(ii)** | |
| Technical Safeguards  **Access Control: Emergency Access Procedure**  **Emergency Access Log** | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Instructions**  This is a procedure under the required *Emergency Access* implementation specification of the Technical Safeguard standard: Access Control. Maintain this log of emergency access activities that involve emergency responders, such as fire department, emergency rescue, law enforcement, paramedic, or business associate (e.g., hardware or software maintenance). The Security Official should assign a *descriptoryyyymmdd*.docx filename for notation in the log, where *yyyymmdd* is the Date of Discovered Emergency. The noted file should contain a Description of the Emergency, including information in columns 2-5 below, how the emergency was resolved, and if there was any impact of networks, systems, applications, devices, or media containing electronic protected health information (ePHI). | | | | | | | |
| **Description of Emergency** | **Date of Discovered**  **Emergency** | | **Workforce Member Initiating Emergency Access** | **Emergency Responder:**  **FD**: Fire Dept.  **LE**: Law Enforcement  **ER**: Emergency Rescue  **P**: Paramedic  **BA**: Business Associate | **Date Emergency Resolved** | | **Security Official Initials**  **and Date** |
| *Filename* | *yyyy/mm/dd* | | *Name, Facility Address, Email, Telephone* | *Code* | *yyyy/mm/dd* | |  |
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| ***HIPAA Integrity*®** | | | **SR, TS 1.4.F** | | | **45 CFR 164.312(a)(2)(iv)** | | |
| Technical Safeguards  **Access Control: Encryption and Decryption**  ***Data at Rest* Encryption Log** | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Instructions**  This is a procedure under the addressable *Encryption and Decryption* implementation specification of the Technical Safeguard standard: Access Control. Maintain this log of workforce member hardware assignment activities and verification of encryption for *data at rest* on the hardware.The Security Official should assign a *descriptoryyyymmdd*.docx filename for notation in the log, where *yyyymmdd* are the dates of hardware assignment, hardware return, and verification of encryption. | | | | | | | | |
| **Hardware Name & Type:**  **S:** S*tationary*  **P:** *Portable* | **Hardware Identifier** | **Assigned Workforce Member User** | | **Date Hardware Assigned** | **Date Hardware Returned** | | **Date**  ***Data at Rest* Encryption**  **Verified** | **Security Official Initials and Date** |
| *Name*  *Code* | *ID#* | *Name, Facility Address, Email, Telephone* | | *yyyy/mm/dd* | *yyyy/mm/dd* | | *yyyy/mm/dd* |  |
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| ***HIPAA Integrity*®** | | | **SR, TS 5.2.F** | | | **45 CFR 164.312(e)(2)(i)** | | |
| Technical Safeguards  **Transmission Security: Encryption**  ***Data in Motion* Encryption Log** | | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Instructions**  This is a procedure under the addressable *Encryption* implementation specification of the Technical Safeguard standard: Transmission Security. Maintain this log of workforce member hardware assignment activities and verification of encryption for *data in motion* on the hardware.The Security Official should assign a *descriptoryyyymmdd*.docx filename for notation in the log, where *yyyymmdd* are the dates of hardware assignment, hardware return, and verification of encryption. | | | | | | | | |
| **Hardware Name & Type:**  **S:** S*tationary*  **P:** *Portable* | **Hardware Identifier** | **Assigned Workforce Member User** | | **Date Hardware Assigned** | **Date Hardware Returned** | | **Date**  ***Data in Motion* Encryption**  **Verified** | **Security Official Initials and Date** |
| *Name*  *Code* | *ID#* | *Name, Facility Address, Email, Telephone* | | *yyyy/mm/dd* | *yyyy/mm/dd* | | *yyyy/mm/dd* |  |
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| ***HIPAA Integrity*®** | | | **SR, BA 1.0.F** | | | **45 CFR 164.308(b)(3)** | |
| Administrative Safeguards  *Business Associate Contracts and Other Arrangements*  **Business Associate Agreement Status Tracking Log** | | | | | | | |
| **Facility**  <Name of Covered Entity or Business Associate>  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Instructions**  **45 CFR 308(b) Business Associate Contracts and Other Arrangements**:  “(1) A covered entity may permit a business associate to create, receive, maintain, or transmit electronic protected health information on the covered entity's behalf only if the covered entity obtains satisfactory assurances, in accordance with 45 CFR 164.314(a), that the business associate will appropriately safeguard the information. A covered entity is not required to obtain such satisfactory assurances from a business associate that is a subcontractor.  “(2) A business associate may permit a business associate that is a subcontractor to create, receive, maintain, or transmit electronic protected health information on its behalf only if the business associate obtains satisfactory assurances, in accordance with 45 CFR 164.314(a), that the subcontractor will appropriately safeguard the information.  (3) *Implementation specifications: Written contract or other arrangement (Required).* Document the satisfactory assurances required by paragraph (b)(1) or (b)(2) of this section through a written contract or other arrangement with the business associate that meets the applicable requirements of 45 CFR 164.314(a).”  The Security Official is responsible for ensuring business associate agreements are current and in place, and this log is for tracking that status. | | | | | | | |
| **Business Associate** | **Contact Information** | **Agreement Execution Date** | | **Agreement Review Date** | **Status**  ***IF****: In Force*  ***R:*** *In Review*  ***T****: Terminated;*  *& Date* | | **Privacy or Security Official Initials & Date** |
| *Company Name* | *Name, Address, Email, Telephone* | *yyyy/mm/dd* | | *yyyy/mm/dd* | *yyyy/mm/dd* | |  |
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