Effective April 14, 2003

LITCHFIELD COUNTY ARC, INC (LARC)

Important
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
[45 CFR164.520(b)]

It is important to read and understand this Notice of Privacy Practices before signing the Consent and Acknowledgment Form.

If you have any questions about this notice, please contact LARC's **Privacy Officer at:**

314 Main Street Torrington, Ct.06790
860-482-9364

Purpose of the Notice of Privacy Practices:

This Notice of Privacy Practices (the "Notice") is meant to inform you of the uses and disclosures of protected health information that we may make. It also describes your rights to access and control your protected health information and certain obligations we have regarding the use and disclosure of your protected health information.

Your "protected health information" (PHI) is information about you created and received by us, including demographic information, that may reasonably identify you and that relates to your past, present or future physical or mental health or condition, or payment for the provision of your health care.

We are required by law to maintain the privacy of your protected health information. We are also required by law to provide you with this Notice of our legal duties and privacy practices with respect to your protected health information and to abide by the terms of the Notice that is currently in effect. However, we may change our notice at any time. The new revised Notice will apply to all of your protected health information maintained by us. You will not automatically receive a revised Notice. If you would like to receive a copy of any revised Notice you should access our web site at www.litchfieldarc.org or contact LARC.

Litchfield County ARC, Inc. personnel understand that information about your health and program is personal. We are committed to protecting health information about you. We create a record of care and description of the services you receive from LARC. We need this record to provide you with quality services and to comply with certain programmatic and legal requirements. This notice applies to all of your Personal Health Information kept and used by LARC..

How We May Use or Disclose Your Protected Health Information

LARC will ask you to sign a consent form that allows us to use and disclose your protected health information for treatment, payment and health care operations. You will also be asked to acknowledge receipt of this Notice.

The following categories describe some of the different ways that we may use or disclose your protected health information. Even if not specifically listed below, LARC, may use and disclose your protected health information as permitted or required by law or as authorized by you. We will make reasonable efforts to limit access to your protected health information to those persons or classes of persons, as appropriate, in our workforce who need access to carry out their duties. In addition, if required, we will make reasonable efforts to limit the protected health information to the minimum amount necessary to accomplish the intended purpose of any use or disclosure and to the extent such use or disclosure is limited by law. [45CFR164.506(a)]

1. **For Treatment** : LARC, Inc.. may use and disclose your protected health information to provide you with treatment and related services. If we are permitted to do so, we may also disclose your protected health information to individuals or facilities that will be involved with your care after you leave LARC and for other treatment reasons. We may also use or disclose your protected health information in an emergency situation. We may disclose information about you to LARC Clinical Services, Day Services, Residential Services, or other departments as required.

For example: Staff and/or volunteers may need to know that you are taking a certain medication or have a condition such as seizures that may effect your program.

- We may disclose your protected health information to doctors, nurses, State of Connecticut Departments providing you services (i.e. Education, Public Health, Mental Health, Mental Retardation, Labor, ICF Inspectors, Motor Vehicles, Workers' Compensation), Federal Departments (i.e. Social Security Administration, Department of Labor, etc), Property Insurance Companies for accident claims, potential or current Employers, Special Olympic Volunteers or Personnel, or other health providers who are involved in taking care of you. For instance, a doctor taking care of you for an injury may need to know if you have diabetes because diabetes may effect treatment.
- We may disclose your protected health information to people such as family members or others who take part in your support outside of LARC.

2. For Payment: LARC may use and disclose your protected health information so that we can bill and receive payment for the treatment and related services you receive. For billing purposes, we may disclose your health information to your payment source, including an insurance or managed care company, Medicare, Medicaid, or another third party payor. For example we may need to give your health plan information about the treatment you received so your health plan will pay us or reimburse us for the treatment, or we may contact your health plan to confirm your coverage or to request prior authorization for a proposed treatment. For example: Litchfield County ARC, Inc. bills and provides information to the State of Connecticut Departments of Social Services and Mental Retardation; the Federal Department of Social Security; other Public Departments/Towns; and/or other Private Payors/Grantors for Administrative, Day, Residential or Clinical Services provided to LARC participants and their families

3. **For Health Care Operations:** We may use and disclose your health information as necessary for operations of LARC such as quality assurance and improvement activities, reviewing the competence and qualifications of health care professionals, medical review, legal services and auditing functions, and general administrative activities of LARC.

For Example:

We may use your protected health information to review our programs and services and to evaluate the performance of our staff and/or volunteers or the performance of a contracted provider.

We may combine health information about many individuals to decide what changes in service might be needed

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4. **Business Associates:** There may be some services provided by our business associates, such as consultants, pharmacies, adaptive equipment companies, billing service or temporary employment. We may disclose your protected health information to our business associate so that they can perform the job we have asked them to do. To protect your health information, we require our business associates to enter into a written contract that requires them to appropriately safeguard your information.

5. **Appointment Reminders:** We may use and disclose protected health information to contact you as a reminder that you have an appointment with other health providers.

6. **Treatment Alternatives and Other Health-Related Benefits and Services:** We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives and to tell you about health related benefits, services, or medical education classes that may be of interest to you.

7. **Public Relations/ Fundraising Activities:** We may use information about you to contact you in an effort to promote and or raise money for LARC and its operations . The information we release will be limited to your contact information, such as your name, address and telephone number and the dates you received treatment or services at LARC. A description of how to opt out of receiving any further public relations and or fundraising communications will be included with any public relations and or fundraising materials you receive from LARC. If you request that your information not be used or disclosed for public relations and or fundraising purposes, we will make a reasonable effort to ensure that you do not receive future public relations and or fundraising communications.

8. **Facility Directory:** With your permission we may post limited, non PHI, information about you in public areas of our facility while you are a participant at LARC including your name, picture, program and/or current general program status. PHI will not be released for individuals admitted to the hospital for psychiatric disabilities, to a substance abuse treatment program, or for HIV testing or treatment without authorization consistent with Section 10 of this document.

9. **Individuals Involved in Your Care or Payment of Your Care:** Unless you object, we may disclose your protected health information to a family member, relative, a close friend or any other person you identify, if the information relates to the person's involvement in your health care to notify the person of your location or general condition or payment related to your health care.

In addition, we may disclose your protected health information to a public or private entity authorized by law to assist in a disaster relief effort. If you are unable to agree or object to such a disclosure we may disclose such information if we determine that it is in your best interest based on our professional judgment or if we reasonably infer that you would not object.

10. Special Rules Regarding Disclosure of Psychiatric, Substance Abuse and HIV-Related Information:. For disclosures concerning protected health information relating to care for psychiatric conditions, substance abuse or HIV-related testing and treatment, special restrictions may apply. For example, we generally may not disclose this specially protected information in response to a subpoena, warrant or other legal process unless you sign a special Authorization or a court orders the disclosure.

Mental health information. Certain mental health information may be disclosed for treatment, payment and health care operations as permitted or required by law. Otherwise, we will only disclose such information pursuant to an authorization, court order or as otherwise required by law. For example, all communications between you and a psychologist, psychiatrist, social worker and certain therapists and counselors will be privileged and confidential in accordance with Connecticut and Federal law.

Substance abuse treatment information. If you are treated in a specialized substance abuse program, Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records. Generally, we may not say to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser, unless:

1. You consent in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of these Federal laws and regulations by us is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the substance abuse program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

HIV-related information. We may disclose HIV-related information as permitted or required by Connecticut law. For example, your HIV-related information, if any, may be disclosed without your authorization for treatment purposes, certain health oversight activities, pursuant to a court order, or in the event of certain exposures to HIV by personnel of LARC, another person, or a known partner.

Minors. We will comply with Connecticut law when using or disclosing protected health information of minors. For example, if you are an unemancipated minor consenting to a health care service related to HIV/AIDS, venereal disease, abortion, outpatient mental health treatment or alcohol/drug dependence, and you have not requested that another person be treated as a personal representative, you may have the authority to consent to the use and disclosure of your health information.

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

OTHER USES AND DISCLOSURES WE MAY MAKE WITHOUT YOUR WRITTEN AUTHORIZATION

Under the Privacy Regulations, we may make the following uses and disclosures without obtaining a written Authorization from you:

1. As Required by Law: We may disclose your PHI when required by law to do so.

2. Public Health Activities : We may disclose your protected health information to a public health authority that is authorized by law to collect or receive such information, such as for the purpose of preventing or controlling disease, injury, or disability; reporting deaths or other vital statistics; reporting child abuse or neglect; notifying individuals of recalls of products they may be using; notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

3. Health Oversight Activities : We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, accreditation, licensure and disciplinary actions.

4. Judicial and Administrative Proceedings : If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to your authorization or a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process if law permits such disclosure.

5. Law Enforcement : We may disclose your protected health information for certain law enforcement purposes if permitted or required by law. For example, to report gunshot wounds; to report emergencies or suspicious deaths; to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.

6. Reporting Victims of Abuse, Neglect or Domestic Violence: If we have reason to believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your health information to notify government authority, if authorized by law.

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

8. Workers' Compensation: We may use or disclose your protected health information as permitted by laws relating to workers' compensation or related programs.

9. Disaster Relief: We may disclose health information about you to an organization assisting in a disaster relief.

When We May Not Use or Disclose Your Protected Health Information

Except as described in this Notice, or as permitted by Connecticut or Federal law, we will not use or disclose your protected health information without your written authorization.

Your written authorization will specify particular uses or disclosures that you choose to allow. Under certain limited circumstances, LARC may condition treatment on the provision of an authorization, such as for research related to treatment. If you do authorize us to use or disclose your protected health information for reasons other than treatment, payment or health care operations, you may revoke your authorization in writing at any time by contacting LARC, Inc. Privacy Officer. If you revoke your authorization, we will no longer use or disclose your protected health information for the purposes covered by the authorization, except where we have already relied on the authorization.

Psychotherapy Notes
A signed authorization or court order is required for any use or disclosure of psychotherapy notes except to carry out certain treatment, payment, or health care operations and for use by LARC for treatment, for training programs, or for defense in a legal action**.**

Your Health Information Rights

You have the following rights with respect to your protected health information. The following briefly describes how you may exercise these rights. [45CFR164.520(b)(1)(iv)]

1. Right to Request Restrictions of Your Protected Health Information : You have the right to request certain restrictions or limitations on the protected health information we use or disclose about you. You may request a restriction or revise a restriction on the use or disclosure of your protected health information by providing a written request stating the specific restriction requested. You can obtain a Request for Restriction form from LARC.. **We are not required to agree to your requested restriction.** If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you with emergency treatment. If restricted protected health information is disclosed to a health care provider for emergency treatment, we will request that such health care provider not further use or disclose the information. In addition, you and LARC may terminate the restriction if the other party is notified in writing of the termination. Unless you agree, the termination of the restriction is only effective with respect to protected health information created or received after we have informed you of the termination. For example, you could ask that we not use or disclose information about past medical information.

To request restrictions, you must make your request in writing to the Litchfield County ARC, Inc. Privacy Officer. In your request, you must tell us:

What information you want to limit;

Whether you want to limit our use of said information, or the disclosure of said information, or both; and

To whom you want limits to apply, for example, disclosures to your sister

2. Right to Access, Inspect and Copy Your Protected Health Information: You have the right to access, inspect and obtain a copy of your protected health information that is used to make decisions about your care for as long as the protected health information is maintained by LARC. To access, inspect and copy your protected health information that may be used to make decisions about you, you must submit your request in writing to LARC . If you request a copy of the information, we may charge a fee for the costs of preparing, copying, mailing or other supplies associated with your request. We may deny, in whole or in part, your request to access, inspect and copy your protected health information under certain limited circumstances. If we deny your request, we will provide you with a written explanation of the reason for the denial. You may have the right to have this denial reviewed by an independent health care professional designated by us to act as a reviewing official. This individual will not have participated in the original decision to deny your request. You may also have the right to request a review of our denial of access through a court of law. All requirements, court costs and attorney's fees associated with a review of denial by a court are your responsibility. You should seek legal advice if you are interested in pursuing such rights. [CFR164.520(b)(1)(iv) & 45CFR164.524]

3. Right to Amend Your Protected Health Information: You have the right to request an amendment to your protected health information for as long as the information is maintained by or for LARC. Your request must be made in writing to LARC and must state the reason for the requested amendment. You can obtain a Request for Amendment form from LARC. We may deny your request for amendment if the information: (a) was not created by us, unless you provide reasonable information that the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by us; (c) is information to which you do not have a right of access; or (d) is already accurate and complete, as determined by us. If we deny your request we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial. We may rebut your statement of disagreement. If you do not wish to submit a written statement disagreeing with the denial, you may request that your request for amendment and your denial be disclosed with any future disclosure of your relevant information. [45CFR164.520(b)(1)(iv) & 45CFR164.526]

Right to An Accounting of Disclosures : You have the right to request an accounting of certain disclosures of your protected health information by Litchfield County ARC, Inc. or by others on our behalf. To request an accounting of disclosures, you must submit a request in writing to the Privacy Officer of Litchfield County ARC, Inc. stating a time period beginning on or after April 14, 2003 that is within six (6) years from the date of your request. The first accounting provided within a twelve-month period will be free.

We may charge you a reasonable, cost-based fee for each future request for an accounting within a single twelve-month period. However, you will be given the opportunity to withdraw or modify your request for an accounting of disclosures in order to avoid or reduce the fee.

Right to Request Confidential Communications: You have the right to request a reasonable accommodation regarding how you receive communication of protected health information. You have the right to request an alternative means of communication or an alternative location where you would like to receive communications. You may submit a request in writing to LARC requesting confidential communications. You can obtain a Request for Confidential Communications form from LARC. [45CFR164.520(b)(1)(iv)]

Right to Obtain A Paper Copy of Notice: You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting LARC. In addition, you may obtain a copy of this Notice at our web site, www.litchfieldarc.org

Right to Complain : You may file a complaint with us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. You will not be penalized for filing a complaint and we will make every reasonable effort to resolve your complaint with you.

To file a complaint with us, you should contact: **The Privacy Officer of Litchfield County ARC, Inc. at 860-482-9364.** All complaints must be submitted in writing to **Litchfield County ARC, Inc., 314 Main St. Torrington, Ct. 06790.**

Changes To This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as about any information we receive about you in the future. We will post a copy of the current notice in our facilities. This notice will contain on the first page, in the top right-hand corner, the effective date. Except when required by law, a material change to any term of the notice may not be implemented before the revised notice becomes effective.

3/2003

[COVERED ENTITY] Effective Date: April 14, 2003

SUBJECT: Patient's Rights - Requesting Access to Protected Health Information.

PURPOSE:

The purpose of this policy is to ensure that [CE] complies with applicable laws that grant individuals or an individual's legal representative (collectively referred to herein as the "individual") the right to request access to their protected health information.

POLICY:

It is the policy of [CE] that individuals have the right to request access to inspect and/or obtain a copy of their protected health information, for as long as the protected health information is maintained by [CE], whether or not the protected health information was created before or after April 14, 2003.

PROCEDURES:

Request for Access

Oral Request for Access: If an individual orally requests a right to access their protected health information, [CE] will provide the individual with a Request for Access to Protected Health Information form. The Request form must be completed, signed and dated by the individual.

Written Request for Access: If an individual submits a written request for access, the Privacy Officer will determine whether the request is adequate based on the information provided.

Incomplete Requests: If the individual's request for access is incomplete, [CE] will send the individual a written Notice of Access Denial form requesting necessary outstanding information so that the request can be processed.

Determining Right of Access: The Privacy Officer shall determine whether a request for access should be granted or denied, in whole or in part, for reasons acceptable under Connecticut and Federal law. Such determination will be made within the applicable timeframe.

Access Granted

Written Notice: If the Privacy Officer determines that [CE] will grant the request for access, in whole or in part, [CE] will complete and send the requesting individual a written Notice of Access Granted form and provide the access requested within the applicable timeframe.

Fees for Copies: The Privacy Officer shall determine the fee to be imposed, if any, for copies within the limitations of the law.

Form of Access: If the Privacy Officer determines that [CE] will grant the request for access, [CE] will evaluate the form or format requested by the individual, and determine if such format is readily producible. If the requested format is not available, [CE] will contact the individual and agree upon another format.

Summary or Explanation: If the Privacy Officer grants the request for access, and the individual has agreed in advance to a summary or explanation of their protected health information, and the applicable fee, [CE] will create a summary or explanation of the individual's protected health information in lieu of providing access. Such summary or explanation will be provided within the applicable timeframe.

Access Denied: If the Privacy Officer determines that [CE] will deny the individual's request for access, in whole or in part, the Privacy Officer must determine whether the individual must be given an opportunity for review of the denial of access.

Unreviewable Denial: If access is denied on unreviewable grounds, [CE] will provide the following information to the requesting individual in a timely manner:

- Notice of Access Denial; and
- Statement of Rights Upon Denial of Access

Reviewable Access Denial: If access is denied on a ground subject to review, [CE] will provide the following information to the requesting individual in a timely manner:

Notice of Access Denial form;

Statement of Rights Upon Denial of Access form; and

Request for Review of Access Denial form.

Request for Review of Access Denied: In the event that the requesting individual submits a request for review of access denial, the Privacy Officer will designate a licensed health care professional that did not participate in the original decision to deny access, to act as a reviewing official.

The Privacy Officer will promptly refer a request for review of access denial to the designated reviewing official and the designated reviewing official will determine, within a reasonable period of time, whether or not to deny the access requested.

Review Determination: The determination of the reviewing official is binding on [CE]. Once the review determination has been made, [CE] will notify the individual by sending a Notice of Review Determination form. If the reviewing official determines that access shall be granted, the procedures set for the above regarding Access Granted shall be followed.

Alternative Access: If access is denied because [CE] does not maintain the information that is the subject of the request, and [CE] knows where the requested information is maintained, [CE] will inform the individual where to direct the request for access by providing the requesting individual with such information on the Notice of Access Denial form.

SUMMARY

RIGHT TO ACCESS, INSPECT, AND COPY

To promote individuals' rights to access, inspect, and copy their PHI.

A. **Generally.** Individuals have a right to request access, an opportunity to inspect and a copy of the individual's PHI, for as long as the PHI is maintained by [CE]. PHI must be maintained and retained by [CE] in accordance with Connecticut and Federal law. [CE] must permit individuals to request access to their PHI. [CE] may require that the request be in writing, provided that such a requirement is set forth in the Notice of Privacy Practices.

1. **No Right to Access, Inspect and Copy**. Individuals do not have a right to access, inspect and obtain a copy of the following information:
   (a) Psychotherapy notes that are maintained separately from the individual's medical record;
   (b) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and
   (c) Records held by a CLIA certified laboratory that are otherwise available to the individual by the individual's health care provider.

2. **Specific access requirement: Tissue slides and blocks.** If [CE] maintains tissue slides or blocks, [CE] must comply with C.G.S. § 19a-490b. In summary, [CE] must provide the individual with a reasonable opportunity to examine retained tissue slides and pathology tissue blocks. Upon the written request of the individual, [CE] must send the original retained tissue slide or block directly to the individual's designated licensed institution, laboratory or physician. If the original slide or block is not available or if a new section cut of the original slide or block is a fair representation of the original slide or block, then [CE] may send the new section cut, which is clearly labeled as such, to the individual's designated health care provider.

B. **Response To Request for Access**:

1. **Time to Respond**. [CE] must respond to an individual's request for access no later than 30 days after receipt of the individual's request.

2. **Extension of Time**. If [CE] is a health care institution as defined by Connecticut Law and is unable to take action within the applicable time to respond set forth above, it may extend the time for such

actions by no more than thirty (30) days provided [CE] provides the individual with a written statement within the applicable time to respond set forth above including the reasons for the delay and the date by which the health care institution will complete its action on the request.

C. **Provision of Access.** If [CE] provides an individual with access to PHI, in whole or in part, [CE] must comply with the following requirements:

1. **Form of Access Requested**. [CE] must provide the individual with access to the PHI in the form or format requested, if it is readily producible in such form or format; or if not, in a readable hard copy form or such other form or format agreed to by [CE] and the individual.

2. **Summary or Explanation**. In lieu of providing access to the PHI, [CE] may provide the individual with a summary or explanation of the PHI requested if the individual agrees in advance to such summary or explanation and to pay any applicable fees imposed by [CE] for such summary or explanation.

3. **Time and Manner of Access**. [CE] must provide the requested access to the individual in a timely manner, discussing the timing and manner of access with the individual as appropriate, including:
   (a) Arranging with the individual for a convenient time and place to inspect or obtain a copy of the PHI; or
   (b) Mailing a copy of the PHI at the individual's address.

D. **Fees.**

1. **Copies**. A reasonable, cost-based fee may be imposed on copies, as long as such fees are not more than 45 cents per page, which fee is inclusive of:
   (a) Copying, including the cost of supplies for and labor of copying, the PHI requested by the individual; and
   (b) Postage, when the individual has requested the copy, summary, or explanation, be mailed.

2. **Radiographs**. A reasonable, cost-based fee may be imposed to cover the cost of materials for furnishing a copy of an x-ray.

3. **Summary or Explanation**. A reasonable, cost-based fee may be imposed for preparing an explanation or summary of the PHI.

4. **Medicare or Medicaid Request**. Generally, [CE] may not charge for furnishing a health record if the record is necessary for the

purpose of supporting a claim or appeal under any provision of the Social Security Act and the request for the records is accompanied by documentation of the claim or appeal.

E. **Denying a Request for Access.**

1. **Unreviewable Grounds for Denial**. An individual's request for access may be denied by [CE] without an opportunity for review, if the individual has requested access to:
   (a) Psychotherapy notes that are maintained separately from the individual's medical record;
   (b) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
   (c) Records held by a CLIA certified laboratory that are otherwise available to the individual by the individual's health care provider;
   (d) PHI held by [CE] acting under the direction of a correctional institution, if access would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting the inmate;
   (e) PHI created or obtained in the course of research that includes treatment. Access to such PHI may temporarily be suspended for as long as the research is in progress, provided that the individual agreed to the denial of access when consenting to participate in the research that includes treatment, and [CE] informed the individual that the right of access will be reinstated upon completion of the research; or
   (f) Information obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

2. **Denial of Access.**

   (a) Reviewable Grounds for Denial. An individual's request for access may be denied by [CE] under the following circumstances, provided that the individual is given a right to have such denials reviewed, if the individual has requested access to:
      (i) PHI that [CE] determines, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety or mental health of the individual or another person;

(ii) PHI that makes reference to another person (unless the other person is a health care provider) and [CE] determines, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

(iii) PHI requested by an individual's personal representative and [CE] determines, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to the individual or another person.

(b) Review of a Denial of Access. If an individual is denied access, the individual is entitled, at the discretion of the individual, to:

(i) Have a reviewable denial (as defined above in subsection a) reviewed by a licensed health care professional who is designated by [CE] to act as a reviewing official, and who did not participate in the original decision to deny access. [CE] must promptly refer a review request to the reviewing official. The reviewing official must determine, within a reasonable period of time, whether or not to deny the access requested. [CE] must promptly provide written notice to the individual of the determination of the reviewing official and take the required action to carry out the reviewing official's determination. [CE] must provide or deny access in accordance with the determination of the reviewing official; or

(ii) In accordance with applicable law or regulation, file a written motion with the appropriate Connecticut court requesting an order that [CE] provide access.

3. **Denial of Access.** If [CE] denies access, in whole or in part, to PHI, [CE] must comply with the following requirements:

(a) Make other information accessible. [CE] must, to the extent possible, give the individual access to any other PHI requested, after excluding the PHI as to which [CE] has a ground to deny access.

(b) Written Denial. [CE] must provide a timely, written denial to the individual**.** The denial must be in plain language and contain the following:

(i) The basis for the denial;

(ii) If applicable, a statement of the individual's review rights, including a description of how the individual may exercise such review rights; and

(iii) A description of how the individual may file a complaint with [CE] or the Secretary. This description must include the name, or title, and telephone number of the contact person or privacy office designated by [CE] to receive complaints.

(c) Alternative Access. If [CE] does not maintain the requested PHI, and [CE] knows where the requested information is maintained, [CE] must inform the individual where to direct the request for access.

4. **Documentation.** [CE] must document and retain the titles of the persons or offices responsible for receiving and processing requests for access by individuals.

Request for Access to Protected Health Information

Name: _____ Date of Birth: _____
Address: _____ Phone Number:_____
_____
_____ Social Security No.: _____

I am requesting access to my protected health information that is currently maintained by [COVERED ENTITY] ("[CE]").

I would like to access my protected health information by (check all that apply):

☐ Inspecting my protected health information.

If my request is approved, [CE] will contact me at the address listed above to instruct me how to arrange for a convenient time and location to inspect my requested protected health information.

☐ Obtaining a copy of my protected health information.

- Would you accept a summary or explanation of your protected health information in lieu of access? ☐ Yes ☐ No
- If my request is approved, [CE] will mail my requested protected health information to the address listed above.
- If you prefer to pick up your information from [CE] during normal business hours, please check here. ☐

I request the following access to my protected health information:

☐ All of my protected health information, or

☐ Some of my protected health information as follows: *(please include specific limitations on dates, episodes of care or other limitations and information to assist [CE] in providing access to a portion of your information):*

_____
_____
_____

I understand that my rights with regard to this request for access are set forth in [CE]'s Notice of Privacy Practices.

By signing this form, I agree to pay the reasonable costs of preparing, copying, mailing or other supplies and labor associated with my request, up to the maximum amount allowed by law.

_____ _____
[Individual Signature] [Date]

Reverse of Request for Access Form

Must be completed by [CE]

Date Request for Access Received: _____

☐ More time needed to respond (Notice of Extension of Time form sent to individual on _____)

Response to Request for Access

☐ Access Granted (the Notice of Access Granted form sent to individual on _____)

☐ Access Denied (Notice of Access Denial form and Statement of Your Rights Upon Denial sent to individual on _____)

☐ Access Granted in part/Denied in part (the Notice of Access Granted form, the Notice of Access Denial form and Statement of Your Rights Upon Denial sent to individual on _____)

Notice of Access Granted

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

Your request for access to your protected health information has been granted:

- ☐ In whole, or
- ☐ In part. Please review the enclosed Notice of Access Denial.

The following applies to that portion of your request for access that has been granted:

- ☐ A hard copy of your protected health information is enclosed or has been mailed to the address you provided.
- ☐ You may pick up a copy of your protected health information at [COVERED ENTITY] ("[CE]") during normal business hours.
- ☐ As you requested, a summary or an explanation of your protected health information in lieu of providing access to the protected health information is enclosed or has been mailed to the address you provided.
- ☐ Please contact us at the number listed below to schedule a mutually convenient time and place for you to inspect your protected health information.
- ☐ The fees associated with your request are $_____. Upon receipt of payment of this fee, we will provide you with the information you requested. Please send payment to [CE] within thirty (30) days of the date of this letter.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Notice of Access Denial

[Date]
[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

Your request for access to your protected health information has been denied, in whole or in part, for the reason(s) listed below. Please see the attached Statement of Your Rights Upon Denial of Access to assist you in understanding and responding to this denial.

Denials Subject to Review. You have been denied access to the information you requested because the information requested:

□ has been determined to be reasonably likely to endanger your life or physical safety or the life or physical safety of another person.
□ makes reference to another person (other than a health care provider) and access is reasonably likely to cause substantial harm to such other person.
□ is being made by a personal representative of the individual and access is reasonably likely to cause substantial harm to the individual who is the subject of the protected health information or another person.
□ Other _____

Denials Not Subject to Review. You have been denied access to the information you requested because the information requested:

□ includes psychotherapy notes that are not subject to access.
□ was compiled in anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
□ involves an inmate and access would jeopardize the health, safety, security, custody or rehabilitation of another inmate or person.
□ was created in the course of research. You may request this information upon completion of the research study.
□ was obtained by [CE] from someone other than a health care provider under promise of confidentiality.
□ is not currently maintained by us and:
    □ we believe the information is maintained by the following person or entity to whom you should direct your request:
        _____
        _____
        _____, or
    □ we do not know where the information is maintained.

□ **Incomplete Request.** You have been denied access because your request was incomplete. Please submit the following items to [CE] in order for your request to be processed:

_____

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Statement of Rights Upon Denial of Access

You have the following rights when you are denied access to your protected health information. The following briefly describes how you may exercise these rights.

Your Review Rights

If your access denial is subject to review as indicated on the Notice of Access Denial, you have the right to request a review of the denial by a licensed health care professional designated by [COVERED ENTITY] ("[CE]"). You may exercise your review rights by submitting the attached Request for Review of Access Denial Form to [CE] at the address listed on the Request Form.

The health care professional reviewing your request will be an individual who was not directly involved in the initial denial of your request for access to your protected health information. The reviewing health care professional will determine, within a reasonable period of time, whether or not to uphold or reverse the denial based on your rights under the Health Insurance Portability and Accountability Act of 1996 and other applicable Connecticut and Federal law.

We will promptly provide you with written notice of the determination of the reviewing health care professional. We will provide or deny access in accordance with the determination of the reviewing health care professional.

You may also have a right to request a review of our denial of access through a court of law. You should seek legal advice if you are interesting in pursuing such rights.

Your Right to Access Other Protected Health Information

If your request for access to your protected health information is partially denied, you have the right to access the approved portion of your protected health information, and the right to request a review of the denied portion, if the information denied is subject to review.

- ***Your Right to File a Complaint***

  You may file a complaint with [CE] or the Department of Health and Human Services, Office of Civil Rights if you believe your privacy rights have been violated. You will not be penalized for filing a complaint and we will make every reasonable effort to resolve your complaint with you.

To file a complaint or to obtain more information, please contact [CE].

[CE] Name
[CE] Privacy Officer
[CE] Address
[CE] Phone

Request for Review of Access Denial

Individual Name: _____ Date of Birth: _____
Address: _____ Phone Number:_____
_____
_____ Social Security No.: _____

I would like to request a review of the decision to deny access to my information as communicated to me in the Notice of Denial Access from [COVERED ENTITY] ("[CE]"), dated _____, for the following reason(s):

_____
_____
_____
_____

I understand that [CE] will promptly refer my request for review to a licensed health care professional designated by [CE] who will not be someone who participated in the original denial decision and that the reviewing health care professional must determine, within a reasonable period of time, whether or not to deny access to the information requested. [CE] will provide or deny access in accordance with the determination of the reviewing health care professional.

_____ _____
Signature Date

Notice of Review Determination

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

The denial of your request for access to your protected health information has been reviewed by a licensed health care professional designated by [COVERED ENTITY] and your request for access has been:

☐ Approved (Please see the enclosed Notice of Access Granted)

☐ Denied for the following reason(s):

_____
_____
_____
_____
_____

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

[COVERED ENTITY] Effective Date: April 14, 2003

SUBJECT: Patient's Rights - Amendment of Protected Health Information.

PURPOSE:

The purpose of this policy is to ensure that [CE] complies with applicable laws that grant individuals or an individual's legal representative (collectively referred to herein as the "individual") the right to request an amendment of their protected health information.

POLICY:

It is the policy of [CE] that individuals have the right to request an amendment of their protected health information, for as long as the protected health information is maintained by [CE].

PROCEDURES:

Request for Amendment.

Oral Request for Amendment: If an individual orally requests an amendment of their protected health information, [CE] will provide the individual with a Request for Amendment of Protected Health Information form. The Request form must be completed, signed and dated by the individual.

Written Request for Amendment: If an individual submits a written request for amendment, the Privacy Officer will determine whether the request is adequate based on the information provided.

Incomplete Requests: If the individual's request for amendment is incomplete, [CE] will send the individual a written Notice of Amendment Denial form requesting necessary outstanding information so that the request can be processed.

Responding to Request for Amendment: The Privacy Officer shall determine in conjunction with the health care provider who created the information subject to the proposed amendment, whether a request for amendment should be accepted or denied for reasons acceptable under Connecticut and Federal law. Such determination will be made within the applicable timeframes.

Notice of Extension of Time: In the event that [CE] is unable to act on an individual's request for an amendment within the applicable timeframe, the Privacy Officer shall send the individual a written Notice of Extension of Time form. An extension of time may only be issued to an individual on one occasion per request for an amendment.

Amendment Accepted:

Written Notice: If the Privacy Officer determines that [CE] will grant the request for an amendment, in whole or in part, [CE] will complete and send the individual a written Notice of Amendment Accepted within the applicable timeframe.

Making the Amendment: If the Privacy Officer determines that the request for amendment shall be granted, [CE] will identify all records that are affected by the amendment and will make the appropriate amendment to the protected health information currently maintained by [CE] by appending a copy of the request for amendment.

Informing Others of Amendment Request Approval: If the Privacy Officer determines that the request for amendment shall be granted, [CE] will make a reasonable effort to notify the following of the amendment within a reasonable time:

Any individuals or organizations identified by the requesting individual on the request for amendment; and
Individuals that [CE] knows have a copy of the protected health information that is the subject of the amendment and that may rely on such information.

Amendment Denied:

Written Notice: If the Privacy Officer denies the individual's request for an amendment, in whole or in part, [CE] will provide the following information to the requesting individual within the applicable timeframes:

- Notice of Amendment Denial form;
- Statement of Rights Upon Denial of Amendment form; and
- Response to Denial of Amendment form.

Statement of Disagreement Submitted: In the event that the requesting individual submits a written statement of disagreement, the Privacy Officer will determine whether or not [CE] will prepare a written rebuttal statement in response to the individual's statement of disagreement.

Rebuttal Statement: If [CE] prepares a written rebuttal statement in response to the individual's statement of disagreement, [CE] will send a copy of the rebuttal statement to the individual.

Future Disclosures: If a statement of disagreement has been submitted by the individual, [CE] will append the individual's request for an amendment, [CE]'s denial of the request, the individual's statement of disagreement and [CE]'s rebuttal statement, if any, or at the election of [CE], an accurate summary of any such information, with any subsequent disclosures of the protected health information to which the disagreement relates.

Statement of Disagreement Not Submitted; Future Disclosure Requested: If the individual does not submit a statement of disagreement, but provides written notice to include information with a future disclosure, [CE] must include the individual's request for amendment and its denial, or an accurate summary of such information, with any subsequent disclosure of the protected health information that is the subject of the amendment request.

Statement of Disagreement Not Submitted; Future Disclosures Not Requested: If the individual does not submit a statement of disagreement and does not provide written notice to include information with a future disclosure, [CE] will not include the individual's request for amendment and [CE]'s denial with any subsequent disclosure of protected health information that is the subject of the amendment request.

Actions on Notices of Amendment: If [CE] is informed by another entity of an amendment to an individual's protected health information, [CE] will identify all records that are affected by the amendment and will make the appropriate amendment to the protected health information currently maintained by [CE] by appending a copy of the request for amendment.

SUMMARY

RIGHT TO AMEND

To promote individuals' right to amend their PHI.

Generally. An individual has the right to have [CE] amend their PHI for as long as the PHI is maintained by [CE]. PHI must be maintained and retained by [CE] in accordance with Connecticut and Federal law. [CE] must permit an individual to request an amendment of their PHI. [CE] may require that the request be in writing, provided that such a requirement is set forth in the Notice of Privacy Practices.

Denial of Amendment. [CE] may deny an individual's request for amendment if [CE] determines that the PHI or the record that is the subject of the request:

Was not created by [CE], (unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment);

Is not part of the medical or billing records;

Would not be available for inspection under the individual's right to access; or

Is accurate and complete.

Response to Request for Amendment.

Time to Respond. [CE] must provide a written response on an individual's request for amendment no later than sixty (60) days after receipt of the request.

Extension of Time. If [CE] is unable to take action within the sixty (60) day period set forth above, [CE] may extend the time for such action by no more than thirty (30) days provided [CE] provides the individual with a written statement of the reasons for the delay and the date by which [CE] will complete its response to the request.

Accepting the Amendment. If [CE] accepts the requested amendment, in whole or in part, [CE] must comply with the following requirements:

Make the amendment. [CE] must make the appropriate amendment to the PHI by, at a minimum, identifying the records that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.

Individual Information. [CE] must timely inform the individual that the amendment is accepted and obtain:

the individual's identification of relevant persons with which the amendment needs to be shared; and

the individual's agreement to have [CE] notify such persons.

Informing Others. [CE] must make reasonable efforts to inform and provide the amendment within a reasonable time to:

Persons identified by the individual as having received PHI about the individual and needing the amendment; and

Persons, including business associates, who [CE] knows has the PHI that is subject to the amendment and that may have relied, or could foreseeably rely, on such information to the detriment of the individual.

Denying the Amendment. If [CE] denies the requested amendment, in whole or in part, [CE] must comply with the following requirements.

Notification of the Denial. [CE] must provide the individual with a timely, written denial in plain language and contain:

The basis for the denial;

The individual's right to submit a written statement disagreeing with the denial and how the individual may file such a statement;

A statement that, if the individual does not submit a statement of disagreement, the individual may request that [CE] provide the individual's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

A description of how the individual may complain to [CE] or to the Secretary, including the name or title, and telephone number of the contact person or office designated for complaints.

Statement of Disagreement. [CE] must permit the individual to submit a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. [CE] may reasonably limit the length of a statement of disagreement.

Rebuttal Statement. [CE] may prepare a written rebuttal to the individual's statement of disagreement, provided [CE] sends a copy of the rebuttal statement to the individual who submitted the statement of disagreement.

Recordkeeping. [CE] must, as appropriate, identify the PHI that is the subject of the disputed amendment, and append or otherwise link the individual's request for an amendment, the hospital's denial of the request, the individual's statement of disagreement, if any, and [CE]'s rebuttal, if any, to the PHI.

Future Disclosures.

If a statement of disagreement has been submitted by the individual, [CE] must include the material appended, or at the election of [CE], an accurate summary of any such information, with any subsequent disclosure of the PHI to which the disagreement relates.

If the individual has not submitted a written statement of disagreement, [CE] must include the individual's request for amendment and its denial, or an accurate summary of such information, with any subsequent disclosure of the PHI that is the subject of the amendment only if the individual has requested such action. When a future disclosure is made using a standard transaction that does not permit the

additional material to be included with the disclosure, [CE] may separately transmit the material to the recipient of the standard transaction.

Actions on Notices of Amendment. If [CE] is informed by another covered entity of an amendment to an individual's PHI, [CE] must amend the PHI.

Documentation. [CE] must document and retain the titles of the persons or offices responsible for receiving and processing requests for requests for amendment by individuals.

Request for Amendment of Protected Health Information

Name: _____ **Date of Birth: _____**
Address: _____ **Phone Number:_____**
_____
_____ **Social Security No.: _____**

I am requesting amendment of my protected health information that is currently maintained by [COVERED ENTITY] ("[CE]").

I request that the following amendment(s) be made to my protected health information:

_____
_____
_____
_____

Please provide the reason(s) for the requested amendment(s):

_____
_____
_____
_____

Please identify individuals or organizations that have received protected health information about you in the past and that should be notified of an amendment to your protected health information.

_____
_____
_____
_____

I understand that my rights with regard to this request for amendment are set forth in [CE]'s Notice of Privacy Practices.

By signing below, I agree that [CE] has permission to notify the persons or organizations listed above or others deemed necessary by [CE] of any amendment accepted by [CE] and related information.

_____ _____
[Individual Signature] [Date]

Reverse of Request for Amendment Form

Must be completed by [CE]

Date Request for Amendment Received:_____

☐ More time needed to respond (the Notice of Extension of Time form sent to individual on _____)

Response to Request for Amendment

☐ Amendment Accepted (the Notice of Amendment Accepted form sent to individual on _____)

☐ Amendment Denied (the Notice of Amendment Denial form and Statement of Rights Upon Denial sent to individual on _____)

☐ Access Granted in part/Denied in part (the Notice of Amendment Granted form, the Notice of Amendment Denial form and Statement of Rights Upon Denial sent to individual on _____)

_____ _____

[Provider Name] [Date]

_____

[Provider Signature]

Notice of Amendment Accepted

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

Your request for amendment of your protected health information has been granted:

- ☐ In whole, or
- ☐ In part (Please review the enclosed Notice of Amendment Denial)

The following applies to that portion of your request for amendment that has been granted:

[COVERED ENTITY] ("[CE]") will make the amendment to your protected health information that is currently maintained by [CE].

Within a reasonable time, we will notify the persons you identified of the amendment. In addition, within a reasonable time, we will make a reasonable effort to inform those we know have a copy of the protected health information that is the subject of the amendment and that may rely on such information.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Notice of Extension of Time

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

We are experiencing a delay in our review of your request for amendment of your protected health information. The reason(s) for the delay are as follows:

_____

We will inform you of a decision on your request for amendment within ninety (90) days of receipt of your original request for amendment.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Notice of Amendment Denial

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

Your request for amendment of your protected health information has been denied, in whole or in part, for the reason(s) listed below. Please see the attached Statement of Your Rights Upon Denial of Amendment to assist you in understanding and responding to this denial.

Reason for Amendment Denial: Your request to amend your protected health information has been denied because:

☐ the protected health information was not created by this organization. If you notify us that the originator of your health information subject to amendment is no longer available, we will review your request for amendment again.
☐ the protected health information is not currently maintained by us.
☐ the protected health information is not available for inspections as required by Connecticut or Federal law.
☐ the protected health information has been determined to be accurate and complete.
☐ your request for amendment was incomplete. Please submit the following items to [COVERED ENTITY] in order for your request to be processed:

_____

_____

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Statement of Rights Upon Denial of Amendment

You have the following rights when you are denied the right to amend your protected health information. The following briefly describes how you may exercise these rights.

You have the following rights with respect to the denial of your request for an amendment to your protected health information or record. The following briefly describes how you may exercise these rights.

Your Right to Submit A Statement of Disagreement

If your request for amendment of your protected health information is denied, you have the right to submit a written statement disagreeing with the denial of all or part of the requested amendment and the basis of such disagreement. You may exercise your right to submit a statement of disagreement by submitting the attached Response to Denial of Access form to the address listed below. The written statement of disagreement must be limited to one written page. If you do not submit a statement of disagreement, you may submit the Response to Denial of Access form to request that we include your request for an amendment and our denial of your request with any future disclosures of the applicable protected health information.

Your Right to Access Other Protected Health Information

If your request for amendment to your protected health information is partially approved or denied, you have the right to amend the approved portion of your protected health information, and to submit a Response to Denial of Amendment form for the denied portion.

- ***Your Right to File a Complaint***

  You may file a complaint with [COVERED ENTITY] ("[CE]") or the Department of Health and Human Services, Office of Civil Rights if you believe your privacy rights have been violated. You will not be penalized for filing a complaint and we will make every reasonable effort to resolve your complaint with you.

  To file a complaint or to obtain more information, please contact [CE].

  [COVERED ENTITY]
  [CE] Privacy Officer
  [CE] Address
  [CE] Phone

Response to Denial of Amendment

Name: _____ **Date of Birth: _____**
Address: _____ **Phone Number:_____**
_____
_____ **Social Security No.: _____**

Please complete this form if you wish to respond to the denial of your amendment request and return it to [COVERED ENTITY] ("[CE]")**.**

☐ I am submitting this statement of disagreement with the Notice of Amendment Denial received from [CE], dated _____, for the following reason(s)(not to exceed one page):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand that [CE] may prepare a written rebuttal in response to my written statement of disagreement and will provide me with a copy of this rebuttal. I understand [CE] will attach my request for an amendment, [CE]'s denial of the request, this statement of disagreement and [CE]'s rebuttal statement, if any, or at the election of [CE], an accurate summary of any such information, with any subsequent disclosures of the protected health information to which the disagreement relates.

☐ I am not submitting a statement of disagreement, but I would like [CE] to include my request for amendment and [CE]'s denial with future disclosures of my protected health information.

☐ I understand that if I do not complete and return this form, or otherwise provide a written response to the Notice of Amendment Denial, [CE] will not include my request for amendment and [CE]'s denial with future disclosures of my protected health information.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Written Rebuttal Statement

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

Thank you for your written statement of disagreement with the denial by [COVERED ENTITY] ("[CE]") of your request for an amendment to your protected health information. [CE] respectfully provides the following rebuttal statement in response to your written statement of disagreement:

_____
_____
_____
_____
_____

We will attach a copy of your request for an amendment, our denial or your request and our rebuttal statement with any future disclosures of your protected health information.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

AMENDMENT NOTIFICATION

To: [Insert Name/Dept.]

From: [Insert Name/Dept.]

CC: [Insert Name/Dept.]

Date: [Insert Date]

Re: **Amendment of Information for the following individual:**

Name: _____ Date of Birth: _____
Social Security Number: _____

We have agreed to a request from the above-referenced individual or the individual's representative to amend the referenced individual's information as outlined on the attached form entitled "Request for Amendment of Protected Health Information."

We believe that you maintain information subject to his amendment. In compliance with Federal law, we are notifying you of this information. You are required to amend this individual's health information in accordance with the attached information and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

If you have any questions, please contact [COVERED ENTITY]

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

[COVERED ENTITY] Effective Date: April 14, 2003

SUBJECT: Patient's Rights - Accounting of Disclosures of Protected Health Information.

PURPOSE:

The purpose of this policy is to ensure that [CE] complies with applicable laws that grant individuals or an individual's legal representative (collectively referred to herein as the "individual") the right to request an accounting of certain disclosures of protected health information.

POLICY:

It is the policy of [CE] that individuals have the right to request an accounting of certain disclosures of their protected health information for the six (6) years preceding the request for an accounting.

PROCEDURES:

Maintaining an Accounting: [CE] shall maintain a written accounting of certain non-routine disclosures of protected health information as required by Connecticut and Federal law.

Oral Request for an Accounting: If an individual orally requests an accounting of their protected health information, [CE] will provide the individual with a Request for Accounting of Disclosures form. The Request form must be completed, signed and dated by the individual.

Written Request for an Accounting: If an individual submits a written request for an accounting, the Privacy Officer will determine whether the request is adequate based on the information provided.

Incomplete Requests: If the individual's request for an accounting is incomplete, [CE] will send the individual a written Notice of Accounting Denial form requesting necessary outstanding information so that the request can be processed.

Determining Right to an Accounting: The Privacy Officer shall determine whether a request for an accounting should be granted or denied for reasons acceptable under Connecticut and Federal law. Such determination will be made within the applicable timeframes.

Notice of Extension of Time: In the event that [CE] is unable to act on an individual's request for an accounting within the applicable timeframe, the Privacy

Officer shall send the individual a Notice of Extension of Time form. An extension of time may only be issued to an individual on one occasion per request for an accounting.

Accounting Granted:

Fees for the Accounting: The Privacy Officer will determine whether the individual has requested more than one accounting within a twelve-month period. If so, the Privacy Officer shall determine the fee to be imposed, if any, for the accounting. If a fee will be imposed by [CE], [CE] will send a Notice of Fee for Accounting form to the individual.

Written Notice: If the Privacy Officer determines that [CE] will grant the request for an accounting and the accounting is in response to the first request for an accounting within a twelve-month period, [CE] has waived any fee associated with the accounting, or the individual has agreed to any fee [CE] will complete and send the individual an Accounting of Disclosures form.

Amendment Denied: If the Privacy Officer denies the individual's request for an accounting, [CE] shall send the individual a Notice of Accounting Denial form.

SUMMARY

RIGHT TO AN ACCOUNTING OF DISCLOSURES OF PHI

To promote an individuals right to receive an accounting of certain non-routine uses and disclosures of the individual's PHI.

A. **Generally.** Individuals have a right to receive an accounting of disclosures of PHI made by [CE] in the six (6) years prior to the date on which the accounting is requested, except for disclosures:

1. To carry out treatment, payment or health care operations;
2. To the individual about his or her own information;
3. Pursuant to an authorization;
4. For national security or intelligence purposes as permitted under law;
5. To correctional institutions or law enforcement officials as permitted under law;
6. That occurred prior to April 14, 2003;
7. Which would impede health oversight or law enforcement activities. The accounting for disclosures of PHI to a health oversight agency or law enforcement official must be suspended for the time period specified by such agency or official if the agency or official provides a written statement asserting that the provision of an accounting would be reasonably likely to impede the activities of the agency or official and specifying a time period for the suspension. If oral notification by a health oversight agency or law enforcement official is given, [CE] must document the notification, including the identity of the agency or official making the request and suspend the individual's right to an accounting of disclosures for no longer than thirty (30) days from the date of the oral statement, unless a written statement is submitted by the agency or official during that time period.

B. **Disclosures of PHI containing HIV-related information**.

1. Connecticut law requires that an accounting of all disclosures of HIV-related information be maintained, unless the disclosure was made to:
   (a) A federal, state, or local health officer when the disclosure is authorized by Connecticut or Federal law; or
   (b) Persons reviewing information or records in the ordinary course of ensuring that a health facility is complying with applicable quality of care standards; program evaluation; program monitoring; or service review.
2. There is no right of law enforcement or a health oversight agency to unilaterally suspend the provision of an accounting of HIV-related information.

C. **Content Requirements:** The written accounting must meet the following requirements:

1. The accounting must include the disclosures of PHI that occurred during the six (6) years (or less as specified in the request) prior to the date of the request (but after April 14, 2003), including disclosures by or to business associates;
2. The accounting of each disclosure must include:
   (a) Date of disclosure;
   (b) Name of entity or person who received the PHI, and, if known, the address of such entity or person;
   (c) A brief description of the PHI disclosed;
   (d) A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or in lieu of a statement, a copy of the written request for disclosure.
   (e) Multiple Disclosures:
      (i) If, during the time period for the accounting, multiple disclosures have been made to the same entity or person for a single purpose, the accounting may provide the information as set forth above for the first disclosure, and then summarize the frequency, periodicity, or number of disclosures made during the accounting period and the date of the last such disclosure during the accounting period.
      (ii) For HIV-related information all disclosures must be included in the accounting (even multiple disclosures to a single person or entity for a single purpose), except for multiple disclosures made to government agents who require information necessary for payments to be made on behalf of individuals pursuant to contract or law, which may be accounted for as set forth above.

D. **Provision of the Accounting.**

Timing. [CE] must act on an individual's request for an accounting no later than sixty (60) days after receipt of such a request. In the event [CE] is unable to provide the accounting within sixty (60) days, [CE] may extend the time to provide the accounting by no more than thirty (30) days if [CE] provides the individual with a written statement of the reasons for the delay and the date by which [CE] will provide the accounting.

Fees. The first accounting in any twelve-month period must be provided to the individual without charge. A reasonable, cost-based fee may be charged for additional accountings within the twelve-month period, provided the individual is

informed in advance of the fee, and is permitted an opportunity to withdraw or amend the request.

E. **Documentation**. [CE] shall retain documentation, in written or electronic format, of all written accountings provided to the individual.

Request for Accounting of Disclosures

Name: _____ **Date of Birth: _____**
Address: _____ **Phone Number:_____**
_____
_____ **Social Security No.: _____**

I would like to request an accounting of certain disclosures of my protected health information made by [COVERED ENTITY] ("[CE]"). I understand that I can only request an accounting of certain limited disclosures made by [CE] during a period of time within the last six (6) years. I further understand that [CE] may deny my request for an accounting of disclosure in certain situations. I understand that my rights with regard to this request for accounting are set forth in [CE]'s Notice of Privacy Practices.

Must be completed by individual or individual's legal representative

Specify time period of disclosures to be included in accounting *(dates must be on or after April 14, 2003)*:

From: ____/____/_____ To: _____/_____/_____

_____ _____
[Individual Signature] [Date of Request]

Must be completed by [CE]

☐ More time needed to comply with the individual's request for an accounting (Notice of Extension of Time for Accounting form sent to individual on _____)

☐ The individual has requested more than one accounting within a twelve-month period:

- ☐ Any fee has been waived by the Privacy Officer, or
- ☐ Notice of Fee for Accounting form sent to individual on _____

☐ Accounting of disclosures provided to individual (Accounting of Disclosures sent to individual on _____)

☐ Accounting of disclosures not provided to the individual (Notice of Accounting Denial sent to individual on _____)

Notice of Fee for Accounting

You have requested more than one accounting of disclosures within a twelve-month period. Although we are required to provide you with the first accounting free of charge, the fee for this accounting will be $_____. Please return this form and indicate below how you wish to proceed regarding your request for an accounting.

☐ I wish to withdraw my request for an accounting. I understand [COVERED ENTITY] ("[CE]") will not provide me with any accounting of the disclosures of my protected health information.

☐ I wish to amend my request for an accounting to reduce the fee as follows:

_____
_____
_____

☐ I am enclosing the fee set forth above payable to [CE]. I understand that [CE] will forward a written accounting of disclosures to me upon receipt of the fee.

_____ _____
[Individual Signature] [Date of

Notice of Accounting Denial

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

Your request for an accounting of disclosures of your protected health information has been denied. You have been denied an accounting of your protected health information for the following reason(s):

☐ [COVERED ENTITY] ("[CE]") has made no disclosures that required an accounting to be maintained.

☐ Your right to receive an accounting of disclosures has been temporarily suspended by a health oversight agency or law enforcement official.

☐ Your request for an accounting was incomplete. Please submit the following items to [CE] in order for your request to be processed:

_____

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Notice of Extension of Time for Accounting of Disclosures

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

We are experiencing a delay in our review of your request for an accounting of disclosures of your protected health information. The reason(s) for the delay include:

_____

We will inform you of a decision within ninety (90) days of receipt of your original request for an accounting.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Accounting of Disclosures

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

In accordance with your request for an accounting of disclosures of your protected health information, we have prepared the following written accounting of disclosures of your protected health information.

Date of disclosure(s) and to whom disclosure was made, including address, if known.	**Brief description of information disclosed and note if a Multiple Disclosure Form is attached**	**Purpose of disclosure or note that a copy of the request for disclosure is attached**
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Multiple Disclosures Form

Disclosure Item: 1 2 3 4 5 Other

Frequency, periodicity, or number of disclosures made during the requested accounting period:

_____
_____
_____

Date of the last disclosure during the requested accounting period: _____.

[COVERED ENTITY] Effective Date: April 14, 2003

SUBJECT: Patient's Rights - Restrictions on Use or Disclosure of Protected Health Information.

PURPOSE:

The purpose of this policy is to ensure that [CE] complies with applicable laws that grant individuals or an individual's legal representative (collectively referred to herein as the "individual") the right to request restrictions on the use or disclosure of their protected health information.

POLICY:

It is the policy of [CE] that individuals have the right to request restrictions on the use or disclosure of their protected health information, for as long as the protected health information is maintained by [CE].

PROCEDURE:

Request for Restriction on Use or Disclosure:

Oral Request for Access: If an individual orally requests a restriction on use or disclosure, [CE] will provide the individual with a Request for Restrictions on Protected Health Information form. The Request form must be completed, signed and dated by the individual.

Written Request for Access: If an individual submits a written request for restrictions, the Privacy Officer will determine whether the request is adequate based on the information provided.

Incomplete Requests: If the individual's request for restriction is incomplete, [CE] will send the individual a written Notice of Restriction Denial form requesting necessary outstanding information so that the request can be processed.

Responding to Request for Restriction on Use or Disclosure: The Privacy Officer shall determine whether a request for restriction on use or disclosure should be accepted or denied for reasons acceptable under Connecticut and Federal law.

Restriction on Use or Disclosure Accepted.

Written Notice: If the Privacy Officer determines that [CE] will grant the request for a restriction on use or disclosure, in whole or in part, [CE] will complete and send the individual a Notice of Agreed Upon Restriction form.

Informing Others of Request for Restriction on Use or Disclosure: In the event restricted protected health information is used or disclosed to a health care provider for emergency treatment, [CE] must request that such health care provider not further use or disclosure the protected health information.

Restriction on Use or Disclosure Denied.

Written Notice: If the Privacy Officer denies the individual's request for a restriction on use or disclosure, in whole or in part, [CE] will provide the requesting individual with a Notice of Restriction Denial form.

Termination of an Agreed to Restriction: [CE] may terminate its agreement to a restriction or the individual may seek to have the restriction terminated if:

the individual agrees to or seeks the termination in writing;

the individual orally agrees and [CE] documents the oral agreement; or

[CE] informs the individual it is terminating its agreement.

[COVERED ENTITY] Effective Date: April 14, 2003

SUBJECT: Patient's Rights - Request for Confidential Communication of Protected Health Information.

PURPOSE:

The purpose of this policy is to ensure that [CE] complies with applicable laws that grant individuals or an individual's legal representative (collectively referred to herein as the "individual") the right to request confidential communication of their protected health information.

POLICY:

It is the policy of [CE] that individuals have the right to request confidential communication of their protected health information.

PROCEDURE:

Request for Confidential Communication.

Oral Request for Confidential Communication: If an individual orally requests to receive communications of their protected health information by alternative means or at alternative locations, [CE] shall provide the individual with the Request for Confidential Communications form.

Written Request for Confidential Communication: If an individual submits a written request for confidential communication, the Privacy Officer will determine whether the request is adequate and reasonable based on the information provided and will accommodate reasonable requests.

Incomplete Requests: If the individual's request for confidential communication is incomplete, [CE] will send the individual a written Notice of Denial of Confidential Communication form requesting necessary outstanding information so that the request can be processed.

Responding to Request for Confidential Communication: The Privacy Officer shall determine whether a request for confidential communication should be accepted or denied for reasons acceptable under Connecticut and Federal law.

Confidential Communication Accepted.

Written Notice: If the Privacy Officer determines that [CE] will grant the request for confidential communication, in whole or in part, [CE] will complete and send the individual a Notice of Agreed Upon Confidential Communication form.

Implementing the Confidential Communication: [CE] shall append the request for confidential communication in the individual's record and made all necessary system changes to comply with the confidential communication request, such as changing contact information in the computer system.

Confidential Communication Denied. If the Privacy Officer denies the individual's request for confidential communication, in whole or in part, [CE] will provide the requesting individual with a Notice of Denial of Confidential Communication form.

SUMMARY

RIGHT TO REQUEST PRIVACY PROTECTION FOR PROTECTED HEALTH INFORMATION

To enable individuals to voluntarily attach greater privacy protections to PHI than otherwise provided.

Generally. Although it need not agree to additional restrictions on uses or disclosures, [CE] must permit an individual to request that [CE] restrict the following:

The use or disclosure of all or some PHI about the individual to carry out treatment, payment or health care operations.

The disclosure of all or some PHI to a family member, relative, close personal friend, or other person identified by the individual directly relevant to the person's involvement with the individual's care or payment.

Emergency Exceptions. Once [CE] agrees to a restriction, [CE] may not use or disclose PHI in violation of such restriction. However, [CE] may use or disclose PHI subject to a restriction if the individual who requested the restriction is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment. [CE] may use the restricted PHI, or may disclose the PHI to a health care provider to provide treatment, but [CE] must request that such health care provider not further use or disclose the information.

General Limitations. A restriction agreed to by a [CE] will not apply to the following:

Required disclosures made to the Secretary;

Uses and disclosures for facility directories;

Uses and disclosures permitted by Connecticut and Federal law for which an authorization or opportunity to agree or object is not required.

Terminating a Restriction. A [CE] may terminate its agreement to a voluntary restriction if:

The individual agrees to or requests the termination in writing.

The individual orally agrees to the termination and the oral agreement is documented.

[CE] informs the individual it is terminating its agreement to a restriction. However, this termination is only effective with respect to PHI created or received ***after*** the individual is informed of the termination.

Documentation. [CE] must document any agreement to restrict use or disclosure of PHI.

Confidential Communications. [CE] must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of PHI from [CE] by alternative means or at alternative locations. [CE] may not require the individual to explain the basis for the request before confidentiality is accommodated.

Conditions on Providing Confidential Communications. [CE] may require the individual to make a request for a confidential communication in writing. [CE] may condition the provision of a reasonable accommodation of confidentiality on the following:

When appropriate, information as to how payment, if any, will be handled.
Specification of an alternative address or other method of contact.

Request for Restriction on Uses and Disclosures of Protected Health Information

I understand that I have the right to request restrictions as to how my protected health information is used or disclosed for purposes of carrying out treatment, payment or health care operations. [COVERED ENTITY] ("[CE]") is not required to agree to my requested restrictions, but if [CE] does agree to such a restriction, the restriction is binding on [CE], except as needed to provide me with emergency treatment.

Please indicate your requested restrictions of uses and disclosures of your protected health information.

☐ I request the following restrictions on the use and/or disclosure of my protected health information for purposes of carrying out treatment, payment or health operations:_____
_____
_____

☐ I request the following restrictions on the use and/or disclosure of my protected health information for purposes of the facility directory:
_____
_____
_____

☐ I request the following restrictions on the disclosure of my protected health information (including my location and general condition, or death) to a family member, relative, or close friends directly involved in my care or the payment of my care: _____
_____
_____

To be completed by [CE]:

Requested Restriction(s):

☐ Accepted

☐ Denied

Notice of Agreed Upon Restriction

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

We have approved your requested restriction regarding the use and disclosure of your protected health information as follows:

_____
_____
_____

This restriction may be terminated at any time by either you or us upon written notice to the other.

If you have any questions, please contact us.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Notice of Restriction Denial

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

We have not agreed to the restriction that you requested regarding the use and disclosure of your protected health information as set forth below:

_____
_____
_____

Your protected health information will however, receive all the protections available under applicable Connecticut and Federal law.

If you have any questions, please contact us.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Termination of Agreed Upon Restriction

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

We are terminating our agreement to the following restriction that you requested regarding the use and disclosure of your protected health information:

_____
_____
_____

This termination is only effective with respect to protected health information created or received after you receive this notification.

If you have any questions, please contact us.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Request for Confidential Communications

I request the following regarding the receipt of communications by alternative means or at an alternative address:

_____
_____
_____

I understand that [COVERED ENTITY] ("[CE]") shall accommodate reasonable requests but may condition my request for confidential communications on how payment, if any, will be handled and my specification of an alternative address or method of contacting me.

To be completed by [CE]:

Confidential Communication(s):

- ☐ Accepted
- ☐ Denied - Request was denied for the following reasonable reasons:

_____
_____
_____

Notice of Agreed Upon Confidential Communication

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

We have approved your request for confidential communication of your protected health information as follows:

_____
_____
_____

If you have any questions, please contact us.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone

Notice of Denial of Confidential Communication

[Date]

[Insert Individual Name]
[Individual Address]

Dear [Insert Individual Name]:

We have not agreed to your request for confidential communication set forth below:

_____
_____
_____

If one of the following boxes is checked, please submit this information to us for additional consideration.

Please provide us with information regarding how payment, if any, will be handled.

Please provide us with an alternative address or other means of contacting you.

If you have any questions, please contact us.

[COVERED ENTITY]
[CE] Privacy Officer
[CE] Address
[CE] Phone