Lorain County
Public Health
Privacy Policy and Procedures

For the Privacy, Security & Standardization of Patient
Records Containing Protected Health Information

(Health Insurance Portability and Accountability Act (HIPAA))

Lorain County
Public Health

For the Health of Us All

Adopted July 15, 2015
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I. General Policies

A. Introduction

Lorain County Public Health (LCPH) will fully comply with all privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-91, as well as all applicable state and federal regulations. These policies will protect health information as required by the provisions of the Health Information Technology for Economic and Clinical Health Act (HITECH), Title VIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act 2009 (ARRA) (Pub.L.111-5). The provisions of this manual and the policies and procedures set forth herein shall be known collectively as the Privacy Manual. Procedures shall be incorporated into the policies set forth herein, and these policies and procedures shall collectively be known as and hereinafter be referred to as policies.

The health record is the property of LCPH and is maintained to serve the patient, health care providers and the agency in legal, accrediting and regulatory agency requirements. The information contained in the health record belongs to the patient and the patient is entitled to the protection of this information. This policy addresses appropriate collection, dissemination, retention, storage, and protection of protected health information (PHI).

LCPH believes patients should be educated to their rights: (a) of confidentiality; (b) to restrict, amend or limit dissemination of PHI; (c) to access information in their health record; and (d) to be informed of LCPH policies and procedures regarding PHI. This policy shall be made known to all employees of LCPH at the time of employment and each employee will receive annual training to review updated guidelines.

B. Responsibilities of Designated Staff

The Director of Administrative Services (DAS) and the Director of Community Health (DCH), with assistance from the Assistant Prosecuting Attorney (APA) employed by the Board of Health of LCPH, shall be responsible for the development and implementation of policies and procedures to safeguard the privacy of patients' health information consistent with federal and state laws and regulations. Responsibilities include:

1. Oversight of the development of policies.
2. Oversight of the development and conducting of training programs on privacy policies.
3. Responding to questions from staff and patients concerning privacy policies.
4. Receiving complaints concerning privacy practices.
5. Auditing compliance with privacy policies.
6. Monitoring changes in federal and state law and regulations that may require changes in this Privacy Manual.
7. Notifying the Board of Health of LCPH of the issuance of new federal or state requirements and the effective date of the same.
8. Development of new or revised policies, as needed, subject to approval by the Board of Health.
9. Revising and updating the Notice of Privacy Practices and other forms, as needed and warranted.
10. Identifying and implementing revisions in orientation and training that may become necessary due to revisions in this Privacy Manual.
11. Communicating, or arranging for the communication of initial, new, or revised policies to affected staff.

These responsibilities may be assigned to other staff members or contractors, but the DAS and DCH shall be primarily responsible for ensuring that these responsibilities are carried out. All policies of this Privacy Manual must be approved by the Board of Health of LCPH, by resolution, prior to implementation.

The DAS is also responsible for compliance with LCPH privacy policies regulations and other state and federal rules. This responsibility includes the management and supervision of:

1. The use of security measures to protect PHI.
2. The conduct of personnel in relation to the protection of PHI.
3. Supervision of all personnel in relation to the protection of PHI.

4. Answer questions from staff concerning disclosure or use of PHI.
5. Designated as the Privacy and Security Officer and is the contact person who is responsible for receiving and processing complaints under this section. The contact person will be able to provide further information about our privacy policies.

Additionally, the DCH is responsible for training and implementation of LCPH privacy policies. This responsibility includes:

1. Assurance that all employees receive initial training and annual refresher/training and education on LCPH's privacy policies and procedures.
2. Documentation of initial training and annual refresher/training.
3. Evaluate adherence to policies and procedures to ensure effective implementation.
4. Audit current policies and procedures to evaluate their adequacy and effectiveness.

All staff are responsible for safeguarding the privacy of patient health information. Each staff member shall be advised of the specific privacy responsibilities of his or her job with LCPH upon hire at orientation sessions and/or at regularly scheduled employee training and review sessions.

Responsibilities of staff include:

1. Use or disclosure of PHI only as authorized in these policies.
2. Conduct oral discussions of PHI with other staff or with patients and family members in a manner that limits the possibility of inadvertent disclosures.
3. Complete the privacy training.
4. Report suspected violations of privacy laws and regulations to DAS.

All staff members are required to know and to identify:

1. The job functions that require the use or disclosure of PHI.
2. The classes of, and the restrictions on, the PHI that the position will use or disclose.
3. The policies which govern the use or disclosure of PHI.

LCPH's obligations to staff are to:

1. Provide a summary of this Privacy Manual and updates thereto.
2. Provide ready access in order to review this entire Privacy Manual.
3. Provide adequate opportunities to ask questions about privacy policies.

II. Privacy Policies

A. General

Some entities have divisions that are covered entities and other divisions that are non-covered entities under HIPAA. These entities are identified as hybrid entities. LCPH is a hybrid entity as defined in 45 C.F.R. §164.103 and includes both covered and non-covered components. Its healthcare component and non-healthcare component, including covered or non-covered, are as follows:

Health Care Component

- HIPAA-Covered Functions
    - Health clinic providing direct patient care including Children with Medical Handicaps Program, immunizations, travel medicine, and other direct patient care activities
- Information that is PHI regulated by federal HIPAA regulations
    - Paper charts, other written information, oral information, and/or electronic data documenting provision of health care or payment for health care of patients who are seen in the health clinic

Non-Health Care Component

- Common Functions Not Covered by HIPAA
    - Epidemiology/Communicable disease investigation and management
    - Care coordination activities including case management for individuals with communicable diseases
    - Animal bite investigations and follow-up
    - Fatality Review Board
    - Child Fatality Review Board
    - Quality assurance assistance on immunizations for health care providers
    - Environmental health activities
    - Air pollution control
    - Food protection
    - Vital statistics
- Information that may contain PHI regulated by the State of Ohio Law but not HIPAA
    - Case management files for individuals with communicable diseases not seen in the clinic
    - Animal bite investigations and follow-up
    - Fatality Review Board records
    - Child Fatality Review Board records
    - COCASA data
    - Ohio Disease Reporting System (ODRS)
    - Healthy Housing and Lead Poisoning Surveillance System (HHLPSS)

Other positions outside of the health clinic must also apply HIPAA laws. The laws apply to anyone working with the PHI regardless of position.

If a covered entity is a hybrid entity, the requirements of HIPAA apply only to the covered health care components of the entity. Any communications between the covered and uncovered portions of the hybrid entity must comply with the privacy and security guidelines. The designated covered components may not share PHI with non-covered components of LCPH unless specifically permitted by the privacy regulations. It is the responsibility of each designated covered component to assure that their employees, students, volunteers, etc. comply with these policies and procedures. A designated covered component may develop and incorporate additional policies and procedures if necessary and appropriate to comply with more stringent state laws. However, a designated covered component may not delete sections of these policies and procedures without first consulting the Privacy Official or the Security Official.

B. Confidentiality of Protected Health Information

1. All health department PHI, including hard copy and computerized data, concerning an applicant, recipient or former recipient of care are considered as confidential information and will be safeguarded to protect the client from exploitation, harassment and/or embarrassment. No employee of LCPH may disclose such information, directly or indirectly, without the client's written authorization, except as required by law, or permitted under the privacy practices of LCPH.

2. Additionally, this policy covers students, volunteers, trainees, contractors, personnel working through a temporary agency, and other persons who perform work for LCPH whether or not they are paid by LCPH.

3. All PHI will be maintained in secured areas. Only authorized provider access to the information will be allowed.

4. Employees shall read and use PHI only as necessary for their job functions. Discussions concerning client's care for the purpose of relaying information shall be discrete and private. Employees will exercise caution when discussing client-sensitive information in an unsecured area.

5. All records, forms, papers, log sheets, etc. with client names on them will be shredded when being disposed according to Lorain County Schedule of Retention and Disposition Policy.

6. PHI maintained in electronic files will be password protected. Computer systems will be in secure locations, have an auto-log-off activation and have anti-virus software installed. All computer systems and data storage units will have a backup for disaster data retrieval. Access to on-line viewing will be controlled through individual, authorized user IDs. Anyone allowing someone else to use his/her access or to otherwise inappropriately access information on the computer may be subject to disciplinary action.

7. Passwords will not be stored in readable form without access control or in other locations where unauthorized persons might discover them.

8. After separation of any employee, all user IDs for that employee will be deleted. It is the responsibility of the DAS to ensure this action is completed.

9. It is the responsibility of LCPH employees to preserve and protect the confidentiality and privacy of health department clients by adhering to department policy, as well as State and Federal laws and regulations.

10. Repeating or in any way disseminating PHI, except as permitted or required by law, is considered unauthorized disclosure of medical information and is a serious offense which may have personal civil and/or criminal liability. In accordance with the health department's personnel manual, violation of this policy may be grounds for disciplinary action up to and including termination.

11. All employees shall be informed of the mandatory nature of confidentiality and be required to sign a security and confidentiality agreement at the time of hire. (See Security and Confidentiality Form in Appendix).

C. Notice of Privacy Practices

1. LCPH will make available a Notice of Privacy Practices (See Notice of Privacy Practices in Appendix) to individuals applying for or receiving covered health care services. Additionally, the department shall make its Notice of Privacy Practices available to any individual(s) upon request, whether or not the individual is an LCPH client.

2. The Notice of Privacy Practices will outline the uses and disclosures of PHI that may be made, and notify individuals of their rights and LCPH's legal duties with respect to PHI.

3. A copy of the Notice of Privacy Practices will be posted in a clear and prominent location where it is reasonable to expect individuals seeking service from LCPH will be able to read the Notice.

4. The Notice of Privacy Practices will be posted on LCPH's website. The notice on the website will reflect the most recent version.

5. LCPH will promptly revise its Notice of Privacy Practices whenever there is a change to the uses or disclosures, the client's rights, LCPH's legal duties, or other privacy practices described in the Notice of Privacy Practices. A revised Notice of Privacy Practices shall be available upon request on or after the effective date of the revision. If a written acknowledgment was previously obtained or a good faith effort documented, another written acknowledgment is not required when the Notice of Privacy Practices is revised. In addition, the revised Notice of Privacy Practices will be promptly posted in a clear and prominent location.

6. Except in an emergency situation, the Notice of Privacy Practices will be available to the client or their personal representative no later than the date of the first treatment service delivery.

7. LCPH will make a good faith effort to obtain a written acknowledgement of the Notice of Privacy Practices from the client or his/her legal representative, except in an emergency situation (See Acknowledgement of Notice of Privacy Practices in Appendix). Exceptions include:
    a. Treatment of an emergency condition, as long as an attempt is made to obtain a written acknowledgement of privacy notice and obtain consent after treatment
    b. Treatment of a patient who is comatose, mentally ill, incapacitated, or otherwise not able to consent to treatment provided.

8. When a written acknowledgement cannot be obtained from the client as described in section 2.3(F), an attempt will be made to receive written acknowledgement and obtain consent from the patient's personal representative before initiating treatment. Such attempt and the reason that written acknowledgement of Notice of Privacy Practice was not provided and consent was not obtained is documented in the medical record. LCPH will not refuse to treat a client because he/she would not sign a written acknowledgment; instead, LCPH should document the good faith effort to obtain the signature. Documentation of a good faith effort shall include the date the acknowledgment of Notice of Privacy Practices was given to the individual and the reason the client refused acknowledgement.

III. Protected Health Information (PHI)

A. Use of Protected Health Information

For the purposes of LCPH policies, the following elements are considered individual identifiers if they are associated with medical information. Such information will be considered PHI and must be protected from improper use or disclosure (See HIPAA List of Identifiers in Appendix).

- Names
- All geographic subdivisions smaller than a state, including street address, city, county, precinct, and zip code
- Dates of service
- Telephone numbers
- Electronic mail addresses
- Social Security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Any other unique identifying number, characteristic, or code that can be reidentified

1. How PHI Will Be Used
    a. PHI will be used for the purposes of treating our clients, obtaining payment for that treatment, and for other health care operations.

    b. In general, seeking payment for treatment will permit our office to share PHI with third-party billing services, and to bill for services to insurance companies, government programs, or other third-party reimbursement sources.

    c. LCPH and authorized state agency personnel may have access to PHI, without authorization from the client, for the purpose of conducting management, financial, or program evaluations, ascertaining the accuracy of financial, administrative, or medical information, and adhering to financial, legal, medical or administrative standards.

    d. LCPH will comply with state law in those situations where disclosure of PHI is required to report incidents of potential criminal activity, abuse or public health disclosures or such other disclosures as may be required by state or federal law.

e. Child Abuse, Injury or Neglect: In accordance with ORC. 2151.421 & 5123.61 the Health Commissioner, the Assistant Prosecuting Attorney, the Medical Director, the Public Health Nurses & all other staff members engaged in public health activities in LCPH who, while acting in his or her official capacity or professional capacity and who knows or suspects that a child under eighteen years of age, or developmentally delayed or disabled, or physically impaired person has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, shall immediately report or cause reports to be made of that knowledge or suspicion to the Lorain County Children Services Board, or to the Lorain County Board of Developmental Disabilities, or to a municipal or county law enforcement officer in the city or county in which the child or person resides or in which the abuse or neglect is occurring or has occurred.

f. Communicable Diseases: ORC. 3701.25 requires certain communicable diseases to be reported to the Ohio Department of Health

g. If health department personnel believe a client may likely cause harm to a third party, they will make a report to law enforcement.

h. Such other exceptions as are provided by law and in the Notice of Privacy Practices of LCPH.

i. LCPH will use PHI to provide, when appropriate, information to our clients concerning the care and treatment of their particular conditions or new developments in medicine that relates to their condition and treatment.

j. LCPH will disclose PHI in emergency situations where such information may be necessary to provide emergency medical care to the client.

2. Release to Legal Representative and/or Immediate Family
    a. In certain circumstances, our clients may have other persons serving as legal representative for the client. In cases where the client has a legally appointed representative, or in the case of a minor child, his/her parent or guardian, we will be permitted to disclose PHI to such individuals upon reasonable verification of their appointment as legal representative or their position as parent/guardian of the minor.

    b. We will also ask our clients in advance if we are permitted to disclose or discuss PHI with other people they specify, such as immediate family members.

3. When releasing PHI over the phone to physicians for the purposes of treatment and or in person to the client, a signed release is not necessary.
    a. Immunization records will be disclosed to physicians via phone on representation by the physician that they are the treating physician of the patient and will maintain confidentiality of the information.

4. Revocation of Authorizations
    a. At any time, the client in writing or verbally may withdraw their consent to release or discuss PHI to third-parties and, any such withdrawal will be duly noted on the client record.

5. Complying with Minimum Necessary Standards
    a. Disclosures of PHI will be limited to the minimum necessary for the purpose of the disclosure, unless we receive an authorization from the client. This provision does not apply to the disclosure of PHI for treatment purposes because physicians, specialists, and other providers need access to the full record to provide quality care. The minimum necessary standard requires that providers make all reasonable efforts to limit the PHI release

to the minimum necessary to accomplish the purpose of use or disclosure.

6. Incidental Use and Disclosure
    a. Uses and disclosures that are incidental to an otherwise permitted use or disclosure may occur, provided that reasonable safeguards and minimum necessary requirements have been met.

    b. This specifically means that our office may use waiting room sign-in sheets; doctors can talk to clients in semi-private rooms, and doctors can confer at nurse's stations without fear of violating the rule if PHI is overheard by a passerby.

7. PHI may be emailed for the purposes of coordinating treatment using the health department's internal secure email or the Ohio Department of Health's secure T-1 line only. All other emails containing PHI are prohibited.

8. How PHI will NOT be used
    a. PHI will not be used for purposes that are not related to health care - such as disclosures to employers to make personnel decisions, or to financial institutions - without written authorization from the client.

9. Psychotherapy Notes
    a. The treating physician should review psychotherapy notes prior to release and the treating professional may withhold release of notes if they believe the release may be detrimental to the best interest of the patient. The notes themselves may not be released although a general description or treatment diagnosis may be used for purposes of payment or health care operations.

10. Disclosure of HIV Test Results or a Diagnosis of AIDS or HIV
    a. ORC. 3701.243 prohibits health care providers and state agencies from disclosing the following information without specific written client authorization. A general medical release is not sufficient.

11. The identity of an individual on whom an HIV test is performed

12. The results of an HIV test (unless anonymous)

13. The identity of any individual diagnosed with AIDS or AIDS-related complex (ARC)

14. Use of Client Photos
    a. Instead of actual client photos for marketing and advertising, LCPH will use generic photos or illustrations to protect the privacy of our clients.

15. Patient Records for Alcohol or Drug Treatment
    a. Federal law provides for the confidenitaliy of alcohol and drug treatment records and such information may not be released without a specific written client authorization.

B. Client Access to Protected Health Information

1. Clients have the right to request a copy of their PHI. Clients will not be required to sign a release in order to receive a copy of their record. However, clients will need to verify their identity through the use of a picture ID, social security number, or HIPAA approved identifier before receiving a copy (see HIPAA List of Identifiers in Appendix).
    a. Phone calls requesting immunization records will be directed to the LCPH website. Residents unable to access the website will need to verify client's name, address, date of birth and social security number. The caller must submit a picture of their ID.
    b. If the client requests a copy of their PHI, LCPH may charge a reasonable copy fee for copies

of their PHI in accordance with the published rates of the Ohio Department of Health. If the PHI is maintained in an electronic form, the client, upon request, may obtain their copies in paper form by mail or an electronic form such as a flash drive or via email using encryption. Copy charges for electronic copies will be similar to the charges if they were photocopied and include the reasonable cost of creating the electronic copy.

2. In the event a client desires to review his/her PHI, but not receive a copy, the client will be given the opportunity to review the record.

3. When the review is requested, a date and time will be scheduled for the review by the DAS. The file must be reviewed in the presence of an employee of LCPH and no material in the file will be permitted to be removed or altered. If a client desires to modify the medical record in any way, he/she will be given the opportunity to submit additional information explaining the reason for the requested revision and which information will be included in the official record (Reference Section 3.4).

4. Special Restrictions for Psychotherapy Notes. The patient may not have access to psychotherapy notes except when the doctor has reviewed such notes and has made a determination that the release of such notes will not be detrimental to the patient requesting access to such information, or unless an exception is otherwise available.

C. Right to Request Privacy Restrictions for Protected Health Information

1. Each client has the right to object to and request restrictions on how their PHI is used or to whom the information is disclosed.

2. LCPH is not required to agree to any requested restrictions. However, if a restriction is agreed to, it is binding, and LCPH may not use or disclose PHI in violation of the agreement, unless otherwise allowed or required under other LCPH policies.
    a. For example, LCPH may disclose PHI to permit emergency treatment
    b. LCPH is also not bound by restrictions when a disclosure is required by law.

3. If the restriction is agreed to, the following procedure must be implemented:
    a. LCPH must honor the restriction;
    b. The restriction must be communicated to the appropriate LCPH staff in an approved manner, such as a note in an electronic record;
    c. Documentation of the approved request must be provided to the client.

4. If the request for restriction is denied, the following procedure must be implemented:
    a. LCPH's denial of the request shall be documented according to LCPH's requirements.
    b. Documentation of the denied request must be provided to the client.

5. LCPH may terminate an agreement to a restriction at any time.
    a. If the client agrees to the termination by LCPH, previously restricted information may be used or disclosed as if a restriction never existed.
    b. If a client objects to the termination, the termination is still in effect, but only with respect to the PHI created or received after the client is informed of the termination of the restriction.

6. The client's right to restrict disclosure of portions of their PHI
    a. A client may ask LCPH not to disclose a part of their medical information to others if the client has paid for the service related to the treatment in full when LCPH may otherwise have billed an insurance company or other persons for such medical services. If requested, and provided not contrary to law, we will segregate that portion of the medical record and specifically note it is to be separate to prevent an inadvertent disclosure of that information if the record is copied and sent pursuant to an authorization or otherwise.

7. LCPH will not disclose any PHI for marketing purposes or sell any such information to other parties, except as expressly permitted by law.

D. Right to Request Amendments to Protected Health Information

1. Each client has the right to request in writing amendments of his/her PHI for as long as the information is maintained by LCPH (See Request for Amendment to PHI in Appendix). It will be LCPH's policy to not delete or change any notation or component of the medical records maintained by us, but will include by insertion additional comments from the client.

2. Each client request for amendment to his/her PHI must be in writing and must include the reason for requesting amendment.

3. If LCPH grants the amendment in whole or in part, the following steps must be taken:
    a. Identify all documents that need to be amended.
    b. Allow insertion of the amendment as an addendum to the contested portion of the PHI; however, the original portion of the PHI may not be deleted.
    c. Inform the requester that the amendment is accepted and obtain the client's identification of an agreement to have LCPH notify the relevant persons with which the amendment needs to be shared.
    d. Make reasonable efforts to inform and provide the amendment within a reasonable time to those identified by the client and to any business associates who have copies of the PHI being amended.
4. LCPH may deny a request to amend a client's PHI if LCPH determines that the information;
    a. Was not created by LCPH (or the originator of the information is no longer available to evaluate the request for amendment);
    b. Is not part of the PHI;
    c. Is accurate and complete.

5. LCPH will provide a timely, written denial to a client that is written in plain language and contains the following elements:
    a. The basis for the denial;
    b. The client's right to submit a written statement disagreeing with the denial and how the client may file such a statement;
    c. A statement that if the client does not submit a statement of disagreement, the client may request that LCPH include the client's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

6. If a client requests review of the denial to amend PHI, LCPH will designate a different individual to review the decision to deny.

7. LCPH will promptly provide written notice to the client of the determination made by the reviewing official. If the notice is a denial, a healthcare professional will provide a written explanation.

E. Disclosures of Protected Health Information With Authorization

1. Disclosure of PHI.
    a. PHI will only be released for purposes other than treatment, payment or operations with the written authorization of the client**,** except as required by law or as authorized under the privacy practices of LCPH (See Authorization for Disclosure of PHI in Appendix).

2. Examples of Situations Where an Authorization May Be Required.

a. The client is treated for a medical condition and requires a letter from LCPH of such treatment in order to return to work with credit for a sick day. A letter cannot be sent to the employer without a written authorization from the client given in advance.
b. The client is examined in an independent medical examination for a workers' compensation claim. The medical report cannot be given without a written authorization signed by the client in advance.
c. A written request is submitted to the office by an attorney for the client for PHI in a personal injury lawsuit. The PHI cannot be duplicated and released to an attorney without a written authorization signed by the client in advance.
d. The client agrees to be interviewed by local media for a story on a public health related matter. If the client signs a release LCPH may release the client's name, address and phone number to local media so the media can contact them for an interview.

3. The authorization must be in writing and a copy of the authorization will be provided to the client. The client can revoke the authorization at any time.

4. Minors or Incompetent Clients
    a. Authorization to release medical information regarding a minor or an incompetent client of any age, must be provided by a parent of the minor, or a legally appointed representative of the minor or incompetent client. There is an exception to this requirement in certain circumstances where a minor must give his/her own consent. In such a situation, he/she is the only person who may authorize a disclosure regarding that portion of the PHI (For example: Minors seen in STD Clinic or for HIV testing).

5. A written authorization, where required, must include the following information:
    a. LCPH's name as the releasing agency
    b. Title of the person or organization receiving the information
    c. Client's name
    d. Extent or nature of the information (specific dates if possible) to be released, including a specific request for any HIV information to be released
    e. A statement that the authorization may be revoked at any time, but not retroactively, and a specific date, event or condition upon which the authorization will expire unless revoked earlier
    f. Date the authorization is signed
    g. Signature of the client or his/her legally authorized representative with relationship noted

6. Release procedures when authorized by the client.
    a. Obtain authorization prior to the release of information. Verify the validity of authorization. A driver's license, social security card or other recognized form of proof of identity shall be required before releasing any PHI to a client/legal representative.
    b. Requests for PHI shall be referred to the DAS. The DAS will ensure all PHI is complete prior to release. All copying of PHI information for release must be coordinated with the appropriate program supervisor.
    c. Specific guidelines are applicable to the release of HIV test result information. A request for the release of such information must be coordinated with the appropriate program supervisor.
    d. An employee who is uncertain about the appropriate response to a request for PHI will refuse to release that information until the employee has consulted his/her supervisor or the privacy officer. Employees will be aware of and responsive to time constraints in responding to subpoenas.

7. The employee releasing PHI from a client record is required to document in the record the following:
    a. The date the PHI is released
    b. The names of the persons and/or agencies receiving the PHI
    c. The specific PHI released.

d. A copy of the completed authorization form shall be sent with the PHI requested and/or to LCPH from which PHI is requested. The original form shall remain in the client's record.
e. This record will satisfy the accounting responsibilities under HIPAA and will be available upon request.

8. Mailing of PHI
    a. PHI mailed to someone other than a medical provider, institution or other recognized service provider or agency will be sent via US mail.

9. Faxing of PHI
    a. Requests from clients with an appropriate authorization to fax PHI to medical providers, institutions or other recognized service providers or agencies will be honored.
    b. The cover sheet used in faxing documents must indicate the confidential nature of the transmission and contain directions as to how the faxed materials are to be handled in the event they are inappropriately received.
    c. The original cover letter used in faxing the PHI with a notation of the disclosed information, date, and identity of the employee making the disclosure must be filed in the client's medical record. The signed authorization from the client or the client's legal representative, if available, will be attached.

10. Disclosure of HIV Test Results or a Diagnosis of AIDS or HIV
    a. ORC. 3701.243 prohibits health care providers and state agencies from disclosing the following information without specific written client authorization. A general medical release is not sufficient.
        i. The identity of an individual on whom an HIV test is performed
        ii. The results of an HIV test (unless anonymous)
        iii. The identity of any individual diagnosed with AIDS or AIDS-related complex (ARC)

    b. Any disclosure of HIV or AIDS information shall be in writing and must be accompanied by the following written statement:
        i. "This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to who it pertains, or as otherwise permitted by state law. A general authorization is not sufficient for the purpose of the release of HIV test results or diagnosis."

11. Disclosure of Patient Records for Alcohol and Other Drug Treatment
    a. Public Health Service Act (42 USC 290dd-3 and Title 42 CFR Part No. S) Restricts the disclosure and use of PHI about individuals with substance abuse issues or treatment. Disclosures of information of substance abuse diagnosis or treatment requires a specific written client authorization. A general medical release is not sufficient.

F. Disclosure of Protected Health Information Without Authorization

1. Law Enforcement and Public Health; Other Disclosures: The provisions in this section delineate the instances and circumstances whereby disclosure of PHI to various government entities is mandated by law. In such cases, the consent or advance authorization of the patient is not required.

2. Disclosure of Patient Information to Public Health Agencies: The following information must be reported to various state and local public health/government agencies as required by law whether or not the patient consents to, or authorizes, such disclosure:

    a. Information required to compile vital statistics (births and deaths)
        i. Ohio Revised Code Section 3705.09 requires a birth certificate for each live birth in

the State of Ohio to be filed with the local registrar of vital statistics in the registration district in which the birth occurs.

ii. In certain circumstances, affidavits of paternity are required by Ohio Revised Code Section 3705.091 to be filed with the Division of Child Support in the Department of Human Services and/or the Ohio Department of Health.

iii. Ohio Revised Code Section 3705.16 requires a death certificate, including details on the disposal of the body, for each death in the State of Ohio to be filed with the local registrar of vital statistics in the registration district in which the death occurs.

b. Information on communicable diseases

i. Medical professionals are mandated by Ohio Administrative Code Sections 3701-3-02 and 3701-3-28 to report information on bites by dogs and other animals to the Health Commissioner of the Health District in which the bite occurred.

c. Medical professionals are mandated by Ohio Administrative Code Sections 3701-3-02 through 3701-3-022 to report to the local Health District the occurrence of cases or suspected cases of various enumerated diseases or ailments, including:

i. Diseases declared to be dangerous and a public health concern because of the severity of the disease or the potential for epidemic spread

ii. Occupational diseases or occupationally related ailments

iii. Air and blood-borne diseases reasonably likely to be transmitted to emergency medical services workers

3. Disclosure to Disaster Relief Agencies: Information on a patient's location or medical condition may be disclosed to disaster relief organizations such as the Red Cross and other such public or private organizations.

4. Disclosure of Patient Information to Law Enforcement Authorities

a. Reporting of Felony

i. Consistent with the mandates of Ohio Revised Code Section 2921.22(A), no staff member, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities.

ii. The situation that staff members are most likely to encounter is a minor patient revealing that he or she is sexually active with an adult. Sexual activity in such situations may constitute Rape under Ohio Revised Code Section 2907.02, a felony of the 1st degree, or Corruption of a Minor under Ohio Revised Code Section 2907.04, a felony of the 4th degree if the offender is four or more years older than the minor.

b. Reporting of Violent Acts: Consistent with the mandates of Ohio Revised Code Section 2921.22(B) and (C), the medical director or any public health nurse giving aid to a sick or injured person shall immediately report to law enforcement authorities:

i. Any gunshot or stab wound treated or observed

ii. Any serious harm to persons that he or she knows and has reasonable cause to believe, resulted from an offense of violence

iii. Any burn injury inflicted by an explosion or other incendiary device or showing evidence of having been inflicted in a violent, malicious, or criminal manner

c. Legal Process from Law Enforcement Authorities: Staff members will, upon receipt of a subpoena, search warrant, or other proper legal process, disclose PHI requested by law enforcement agencies or prosecuting attorneys without obtaining the patient's consent or authorization. Staff shall refer all requests for PHI that are received from law enforcement authorities in such manner to APA for review and approval prior to responding to requests.

5. Disclosure of Patient Information to Oversight Agencies: Staff members may disclose PHI to government agencies such as the Ohio Department of Health, the Ohio Department of Jobs and Family Services, the Federal Office of Health and Human Services, the Federal Office of Homeland

Security, and the Federal Centers for Disease Control, agencies which are responsible for administering public health programs such as Medicare and Medicaid, and other agencies which license providers, which conduct audits, and which perform other functions and possess other responsibilities and duties relative to the oversight of the health system or the preservation of the public health.

6. Disclosure of Patient Information Subject to Family Educational Rights and Privacy Act (FERPA)
    a. FERPA (20 U.S.C. § 1232g; 34 CFR Part 99) is a federal law that protects the privacy of students' "education" records. It allows parents the right to access their child's record, have it amended, and the right to provide consent for disclosure of any personally identifiable information, unless an exception to consent applies (See 34 CFR Part 99, Subparts B, C, and D). These rights transfer to the student when the student reaches 18 years or attends a postsecondary institution at any age thereby becoming an "eligible student".
    b. LCPH contracts with public and private elementary and secondary schools to provide school health services. Student health records that are created and maintained by LCPH, acting as a third-party contractor, for a FERPA-covered elementary or secondary school, would qualify as "educational records" and therefore be subject to FERPA and not HIPAA.
    c. Under FERPA, a parent, or "eligible student", must provide written consent prior to the release of any personally identifiable information from the student's educational record. Exceptions to the consent rule are set forth in 20 U.S.C. §§ 1232g(b)(1), (b)(2), (b)(3), (b)(5), (b)(6), (h), (i), and (j), and 34 CFR § 99.31. For example, a school nurse may share health and medical information in the student's educational record to teachers and other school officials within the school, without prior written consent, if these school officials have been determined to have "legitimate educational interest" in the record. A school nurse may also share health and medical information in the student's educational record to appropriate parties in connection with an emergency, if these parties' knowledge of the information is necessary to protect the health or safety of the student or other individuals.
    d. Student health records that are created and maintained by (LCPH) for services provided directly to students, in which LCPH is not acting for a FERPA-covered educational agency or institution, do not constitute FERPA-protected education records. For example, the records created and maintained by a public health nurse who provides immunizations at a clinic that is located on a FERPA-covered elementary or secondary school's grounds, but who is not acting for the school, would not qualify as "education records" under FERPA. In this situation, the health records would fall under HIPAA and shall be maintained accordingly.
    e. FERPA and HIPAA Joint Guidance; https://studentprivacy.ed.gov/resources/joint-guidance-application-ferpa-and-hipaa-student-health-records.

7. Disclosure in Civil Legal Actions: Staff may disclose PHI for use in a legal proceeding when:
    a. The information has been ordered released by a court order or an order of an administrative tribunal, or
    b. The information has been requested by means of a subpoena, discovery request, or other legal process.
    c. Staff members, when presented with a court order, subpoena, discovery request or other such legal process shall consult with LCPH legal counsel before releasing the requested information.

8. Disclosure to Avert a Threat to Health or Safety: A staff member may disclose PHI without the consent or authorization of the patient, if in the staff member's professional judgment, such disclosure is necessary to reduce a serious and imminent threat to the health and safety of a person or the public.

G. Responding to a Subpoena

When served with a subpoena for PHI, take the following steps:

1. Document the circumstances of receipt (i.e., date, time, and manner of service, person served).

2. Notify your supervisor of the receipt of the subpoena. With the supervisor, review subpoena for required information and time for compliance. Determine whether client has signed authorization. Authorization should accompany subpoena.

3. If the subpoena is not accompanied with an authorization, the supervisor will notify DAS and Health Commissioner, who will contact the Prosecutor's Office for legal representation and request a motion to quash the subpoena.

4. If the subpoena and authorization are valid, compile and review material responsive to the subpoena.
    a. Do not produce information not within scope of subpoena.

5. Copy the materials and prepare a certification for records.
    a. Contact counsel to ensure that copies are acceptable in lieu of originals.
    b. Make notes of materials produced for records.

6. Comply with the subpoena
    a. If only the record is required and not an appearance by a specified individual, send the documents with certification within time specified.
    b. If a specified individual is required to attend, bring copies of record together with certification (ensure that copies are acceptable in lieu of originals).

H. Accounting for Disclosure of Protected Health Information

1. LCPH will keep account for any disclosure of PHI from an electronic medical record which is made for other treatment, payment, or practice operations. No accounting, however, will be required for the release of PHI which was done in a paper or non-electronic format for billing or medical treatment purposes, except as otherwise required by law.

2. A record of the disclosure of PHI will be maintained for (a) any disclosure that was electronic or (b) if the disclosure was in paper form, for reasons other than medical treatment, billing or operations. For example, a return-to-work letter must be noted. An independent medical examination report must be noted.

3. A list of all PHI disclosures will be kept in the patient's chart (See Accounting of Disclosures of PHI in Appendix). Such list will be maintained for a minimum of six years from the date of disclosure and thereafter consistent with LCPH records retention and disposition policy. If the disclosure was made electronically using electronic medical records systems, an appropriate log or other system accounting device will be used to track the disclosures of PHI and will include in the listing the date of disclosure, the name and address of the person to whom the PHI was sent, a brief description of the PHI disclosed, and the purpose for which the PHI was disclosed. A copy of the authorization for the disclosure will be included in the chart.

4. Each client has a right to receive an accounting of disclosures of his/her PHI made by LCPH at any time during the previous six years (See Request for Accounting of Disclosures of PHI in Appendix). This includes any disclosures made to or by any business associate of LCPH. An accounting of disclosures made in paper form will be provided to the client, but disclosures of the following type do not have to be included on the accounting of disclosures:
    a. Disclosures made to the client;

b. Disclosures made based upon signed authorization of the client or personal representative;
c. Disclosures for purposes of treatment, payment or health care operations.

5. LCPH shall require requests for accounting of disclosures to be in writing and forwarded to the appropriate program supervisor for action.
    a. LCPH will provide for a complete accounting of any disclosed information as follows:
    b. Date of the disclosure;
    c. Name and address of the organization or person who received the PHI;
    d. Brief description of the PHI disclosed
    e. For disclosures other than those made at the request of the patient, the purpose for which the information was disclosed and a copy of the request or authorization for disclosure.

6. Disclosures made to health oversight agencies or law enforcement officials may be temporarily excluded from an accounting if the covered agency has been notified by the oversight agency or law enforcement official that providing an accounting could impede the progress of their activities.

I. Privacy Complaints

1. Privacy complaints will be documented, investigated, and resolved in a timely manner, ensuring clients and other individuals that LCPH is committed to protecting the health information that is created, received, and maintained by LCPH.
    a. Investigations will focus on both the specific privacy complaint and any patterns of similar privacy complaints.
    b. Documentation of privacy complaints, investigative efforts, and complaint disposition is considered administrative information and shall be maintained by the Privacy Officer for at least six (6) years.
    c. Documentation of privacy complaint information shall not be filed in a client's record.

2. LCPH will make every effort to ensure documentation of privacy complaints is accurate and reflects the complainant's concerns.

3. LCPH shall make a good faith effort to have all complaint documentation signed by the client or representative and will use the same procedures for obtaining signatures for privacy complaints as they use to obtain signatures for authorizations. If a client or representative appears in person the complaint information may be documented by the client or representative or by the Privacy Officer, at which time the client or representative will be requested to sign the documentation. Written documentation received through the US mail, e-mail, or facsimile from the client or representative shall constitute signature. Telephone complaints shall be documented by the Privacy Officer. A copy of the documented complaint shall be sent to the client or representative with a request for signature. Regardless of whether a signed copy of the form is returned by the client or representative the sending of a copy constitutes a good faith effort to obtain signature. Investigation of a complaint shall begin immediately following receipt of the complaint.

4. Protection of Whistle Blowers: LCPH will not retaliate against any individual for filing a privacy complaint with LCPH. No action shall be taken against a staff member for reporting a violation of privacy policies and procedures.

5. Investigation of Possible Violations: In the event the personnel of LCPH should determine that a potential violation of the policies has occurred which could compromise the security or privacy of PHI, it shall be reported to the DAS who will begin or have another designated person begin an investigation of such event. (See Investigation of Potential Privacy Breach in Appendix)
    a. Investigation and Risk Assessment
        i. The investigator will make inquiries to determine what occurred, who obtained access to the protected information, if the person or persons had an appropriate

reason for such access, and determine how an unauthorized person obtained access, if applicable.

ii. The investigator will conduct a risk assessment to determine whether the events posed a significant risk of financial, reputational or other harm to the insured. The investigator, as part of that assessment, will also consider the type and amount of PHI that was involved in the impermissible use or disclosure.

iii. If the investigation concludes that the breach was unintentional, made in good faith, and within the scope of general authority, and further confirms that the information was not further disclosed or used, except as authorized by the privacy rules, it is not considered to be a breach.

iv. If the investigator concludes that it is an inadvertent disclosure and can confirm that the information was not further used or disclosed in a manner not permitted by the privacy rules, or has confirmed that the unauthorized person could not have reasonably been able to retain or keep such information, then such actions will also not be deemed a breach.

v. If the PHI was in electronic form and the information was encrypted and a disclosure of the information in the encrypted form occurred, with the encryption being one of the forms currently approved by the Secretary of Health and Human Services, then such disclosure is also not considered a breach.

Examples of violations may include:

- Technical violations - When obtaining a consent, a staff member fails to notice that the patient signed, but did not date the consent form.
- Accidental disclosure - Information on two patients is accidently mixed-up and the wrong information is sent to third parties.
- Intentional disclosure - A staff member provides a drug company representative a list of patients with individually identifiable medical conditions, without obtaining authorization from the patients for this disclosure.

b. Notices to Individuals: If after conducting the investigation and risk assessment, it is determined that a breach has occurred, then the person shall prepare a summary of their findings. As soon as possible, but no later than 60 days after the confirmation that a breach has occurred, we will provide written notice to the client or clients, whose information was disclosed or accessed, including the following information within the Notice:

i. Description of what happened, the date of the breach, and the date of the discovery of the breach, if known;

ii. A description of the types of PHI that were involved in the breach, such as name, social security number, address, diagnosis, date of birth, and other types of information;

iii. Steps the insured should take to protect themselves from potential harm by virtue of the breach;

iv. A description of what steps we have taken to investigate the breach, to mitigate harm to the patient, and to protect against future breaches; and

v. Identify contact procedures for the appropriate person at LCPH, including telephone number, mailing address, and email address, if applicable.

vi. The Notices will be sent by first class mail or by electronic mail if the client had given such information to LCPH, or if LCPH knows that the client has died, the Notice will be sent to the next-of-kin or personal representative of the insured.

c. Substitute Notice: In the event that LCPH no longer has current contact information for the client, LCPH will take the following steps:

i. If fewer than 10 clients are involved for which there is out-of-date contact information, then LCPH will attempt to reach such clients by an alternate form of written notice, telephone or other means;

ii. In the event that there is insufficient or out-of-date contact information for 10 or more

clients, then the Notice shall: (a) be posted on the LCPH website, or (b) included in a conspicuous notice in the major newspaper or broadcast media in the area of the clients and include in such notice a toll-free number where clients can contact LCPH for at least 90 days concerning the situations.

d. Emergency Notice: In the event that a breach has occurred, which we determine in good faith requires more immediate notice, LCPH will accelerate the time of giving notice to the client, including telephone or other means.

e. Notification to the Media: In the unlikely event that a breach of unsecured PHI involves more than 500 clients, then in addition to the notices described above, we will contact prominent media outlets serving our area, providing a general description of the same information provided above, without identifying the specific name of the clients, but describing the circumstances, and contact procedures for the appropriate person at LCPH.

f. Notification to the Secretary of Health and Human Services: In the event a breach has occurred for which notice is required, the DAS will maintain a log or other documentation describing each of the breaches and the steps taken by LCPH to provide notice. In addition, the DAS will report to the Secretary the incident, as required at the U.S. Department of Health and Human Services' website by completing the online notification reports in the categories of 500 or more or less than 500 individuals as provided. The website is currently: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html.

IV. Security Standards

A. Client Security Information

1. It is our policy to maintain confidentiality of all clients' information and to adopt security standards to prevent access to such information by unauthorized persons. This includes protecting information stored electronically and in paper form.

2. Administrative Safeguards
    a. The LCPH Privacy and Security Officer will conduct an assessment of potential risks and vulnerabilities to the confidentiality, integrity and availability of electronic PHI held by LCPH. The LCPH Privacy and Security Officer will further implement security measures to reduce risks and vulnerabilities and to protect against reasonable anticipated threats or hazards to the security or integrity of such information, and to prevent unauthorized disclosure of such information.

3. The LCPH Privacy and Security Officer will further periodically perform a security risk assessment of our records to assure continued updates and compliance, and to respond to any incidents of breaches of security.

4. Physical and Technical Safeguards: All protectable information, which is in an electronic format, will be password protected. Computer systems will be in secure locations and will have an automatic log-off and anti-virus software installed. Only individuals who require access to this protected information will have access to the electronic system. In addition, any private information in paper form will be maintained in secured locations, and only personnel having a reasonable need to access such records will be permitted to do so.

5. Emergency Management, Backup and Disaster Plan
    a. This Health Department is required by various federal and state laws to draft, and have on file and readily available contingency plans for bioterrorism attacks and other such

emergencies. Those plans, as they now exist and as they may hereafter be adopted by this Health Department as part of separate emergency planning programs, are adopted and incorporated herein by reference into this Security Manual.

b. Electronically stored information will be backed up on a periodic basis with offsite storage. This material will be in a form permitted to be retrieved in the event of a disaster or other destruction of electronic records. While all records are to be password secured, the LCPH Privacy and Security Officer or their designee will have access to medical records in the event of an emergency.

6. Facsimiles: No confidential client information will be faxed unless precautions are taken to assure the recipient is known.

7. Medical Files: All clients' records will be maintained in secured areas. Only persons with reasonable need to use the information will be allowed access to such information.

8. Oral Communication: Our employees will be instructed to exercise caution when discussing client-sensitive information in an unsecured area.

9. Training: Specific training will be provided regarding the security measures necessary for compliance with these policies.

10. Audit: The LCPH Privacy and Security Officer will periodically audit and review our systems to verify ongoing compliance with these security standards.

11. Business Associate Agreement: The requirements to implement information will be incorporated in our Business Associate Agreements.

12. Record Destruction: All paper records containing protectable information will be destroyed by shredding or other secured methods. Information in electronic form will contain programs and features that will prevent the ability to access previously deleted data in accordance with the recommendations from our information technology consultants or vendors.

B. Business Associate

1. All of our business associates will have a written Business Associate Agreement (See Business Associate Agreement in Appendix) signed protecting LCPH in the event a business associate mishandles protected information.

2. Business associates may include, but are not limited to, outside contractors, compliance consultants, attorneys, information technology contractors, third-party billing companies, suppliers and temporary staffing firms.

3. All of our business associates must confirm in writing to us that they have a HIPAA compliance plan which covers the privacy regulations and security standards and further, includes the provisions required by HITECH. The business associate must agree to coordinate investigations of any breaches with us and to take other steps as we may require from time to time to protect the privacy of PHI. All business associates must sign and agree to all provisions in the Business Associate Agreement. It will be the responsibility of the DAS to ensure Business Associate Agreements are completed and on file.

C. Training and Education

It is LCPH's policy to inform our employees and business associates to comply with the privacy policies of LCPH. We will conduct training programs for all current employees to describe the privacy policies of LCPH and the importance of such policies. The Director of Community Health (DCH) will ensure all employees receive initial training and an annual refresher and education on LCPH's privacy policies and

procedures, and the training will be documented (See Security and Confidentiality Agreement in Appendix).

1. Privacy Training Program for Staff
   DCH or a staff member designated by DCH will develop a privacy policy orientation and training program. The purpose of this program shall be to ensure that all staff members are familiar with LCPH's privacy policies. Training methods can vary depending on content. The training and orientation program will cover:
   a. The definition and identification of PHI
   b. The Notice of Privacy Practices form that is to be available upon request to all patients
   c. Using and disclosing PHI without a patient's consent, under the HIPAA Privacy Rule, for purposes of treatment, payment and LCPH operations
   d. Using and disclosing PHI with a patient's consent for purposed not covered under the HIPAA Privacy Rule
   e. Procedures for handling suspected violations of privacy policies
   f. Penalties and disciplinary actions for violations of privacy policies
   g. Documentation of compliance with privacy mandates and safeguards

2. Initial Privacy Orientation and Training: All newly hired staff members must:
   a. Complete the privacy policy orientation and training program during their probationary periods.
   b. Completion of the privacy policy orientation and training program will be documented in the employee's personnel file by Privacy Officer or by the staff member who conducts the training.
   c. Until newly-hired staff members complete the privacy policy orientation and training program, their supervisors will closely monitor their use and disclosure of PHI.

3. Training Existing Staff on Policies and Procedures:
   a. All existing staff will receive an annual refresher and/or training. If there are major changes to the policy and procedures, LCPH may hold a training when changes take effect.
   b. Staff whose job responsibilities are affected by a change in privacy policies must complete training on the revised policies within two (2) months of their effective date.
   c. Completion of training will be documented for each employee.

D. Penalties

1. We believe that the rights of our patients and the protection of their PHI is extremely important. In the event that any employee should violate the policies and procedures of the practice regarding such confidentiality, such employee will be subject to immediate discipline and re-education or based upon the severity of the violation, may be subject to immediate discharge. These repercussions will be explained and disclosed to employees during training sessions.

2. Sanctions for Staff Violations
   Employees are prohibited from improperly using or disclosing confidential patient information as detailed in this policy and procedures. Such improper uses include but are not limited to curiosity, malicious purpose, or financial gain. In addition, employees are expected to comply with all policies involving HIPAA-mandated computer security. Employees who violate these policies will be subject to sanctions as detailed in this policy and/or LCPH's Personnel Policy.
   a. Any staff member observing a privacy or security violation is to report the violation to his/her supervisor. Failure to report a violation is a disciplinable offense.
   b. The supervisor should refer the incident to the LCPH Privacy and Security Officer. The LCPH Privacy and Security Officer, in conjunction with other management personnel as deemed appropriate, shall investigate the matter through discussing the matter with staff, patients, or others and/or review of computer or paper audit trails.

c. The Privacy and Security Officer and the employee's supervisor and/or director will evaluate the severity of the violation, the degree of harm caused, the frequency of past violations, and the employee's overall record of performance with LCPH. Based on this evaluation, one or more of the following sanctions will be applied:
    i. Coaching on allowed uses and disclosures
    ii. Formal warning
    iii. Formal reprimand
    iv. Requirement to review policies and procedures
    v. Suspension from 1 to 30 days without pay
    vi. Termination
d. For significant violations, such as uses or disclosures for financial gain or made with malicious intent, immediate termination may be appropriate. For other violations, because of the wide variety of types of violations possible and circumstances involved, considerable flexibility in administering sanctions is given to the Health Commissioner or designee.
e. The Privacy Officer, in conjunction with other members of the management staff as he/she deems appropriate, shall take action to mitigate the harmful effects of the privacy violation, if this is reasonable and possible.
f. A written incident report will be written by the Supervisor and/or Privacy Officer and filed in the Privacy Officer's privacy violations file and in the employee's personnel file. A copy of the incident report will be given to the employee.

E. Amendments and Modifications

1. This procedure manual may be amended or modified based upon subsequent revisions in government regulations or subsequent interpretations of those regulations requiring appropriate modifications.

2. It is further our policy that to the extent that any state or federal law requires additional protection for the rights of patients and the use of their information, that the more restrictive law will apply. As previously noted, to the extent state law requires disclosure of information, such is our policy to comply with that state law and its mandated disclosures.

Lorain County Public Health
9880 Murray Ridge Road
Elyria, Ohio 44035
440-322-6367 (phone) 440-322-0911 (fax)

SECURITY AND CONFIDENTIALITY AGREEMENT

As an employee of Lorain County Public Health (hereinafter "LCPH") and as a condition of my employment, I agree to the following:

1. I understand that I am responsible for complying with the LCPH Privacy Policy and Procedures (HIPAA Policy), which were provided to me.
2. I will treat all PHI received in the course of my employment with LCPH, which relates to the clients of LCPH, as confidential and privileged information.
3. I will not access PHI unless I have a need to know this information in order to perform my job and am authorized.
4. I will not disclose PHI regarding LCPH's clients to any person or entity, other than as necessary to perform my job, and as permitted under LCPH Privacy Policy and Procedures.
5. I will safeguard my computer password and will not post it in a public place.
6. I will not allow anyone, including other employees, to use my password to log on to the computer, and will not use anyone else's password.
7. I will log off of the computer as soon as I have finished using it.
8. I will not use e-mail to transmit PHI unless I am instructed to do so by the Privacy Officer.
9. I will not take PHI from the premises of LCPH in paper or electronic form without first receiving permission from the Privacy Officer.
10. Upon cessation of my employment with LCPH, I agree to continue to maintain the confidentiality of any PHI I learned while an employee and agree to turn over any keys, access cards, or any other device that would provide access to LCPH or its information.

I understand that violation of this agreement could result in disciplinary actions and/or other legal repercussions.

_____ _____
Name (print) Date

_____ _____
Name (signature) Witness

LORAIN COUNTY PUBLIC HEALTH
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.

Our Legal Duty

We are required by law to keep your health information private and secure and to tell you about how we may share it. We must also tell you about our duties and your rights concerning your health information. If we change the way we protect your information, this form will be updated and you may ask for a copy.

Ways We Use and Share Health Information

Your information may be shared in three main ways -

Treatment: We may share your health information with a healthcare provider who is treating you; to refer you to a specialist, or to refer you to another program at the Health Department. If you are in the military we may share your information with them if it helps provide care to you. Unless you tell us not to, we may send mail, call, or e-mail you to remind you about an appointment.

Payment: We may share your information to get payment for services you received. For example, we will tell your health insurance company about the services you received so they can pay the bill.

Health Care Operations: We may share your information to support business activities, such as quality improvement activities, health care or financial reviews, or staff training.

Other ways we may share your information.

To You or with Your Permission: We can always give you your information or we can share it with someone else with your written permission. If you tell us, in writing, to stop sharing it with those persons, this will only stop future sharing of information and will not undo the information previously shared.

To Your Family and Friends: We may share your health information with your family or a close friend that is involved in your care. We will do this with your permission unless you can't give permission or it is an emergency.

To Emergency agencies: We may share your health information with Disaster Relief Agencies, such as the Red Cross, or first responders to help provide you emergency care and disaster relief.

To Prevent a Public Health Risk. We may share your information to prevent or investigate a disease outbreak; to prevent injury to others; to report births and deaths; and to help notify you when product recalls happen. This also includes anything needed to prevent or lessen any serious threat to the health or safety of any person including threats to national security.

Health Oversight Activities. We may legally share your health information with another government agency to improve the quality of the way your service is provided or billed. They may review records, licenses, inspections, or other documents or actions. These are needed to check on the quality of various parts of the health care system; government payment and licensing programs; and civil rights laws.

Abuse or Neglect. We may share your health information with local authorities if we believe that you or a child might be a possible victim of abuse, neglect, domestic violence or other crimes.

Coroners, Medical Examiners, Funeral Directors: We may share your information with a coroner or medical examiner in order to assist in the cause of death or to help a funeral director in doing their job.

Lawsuits: If you are part of a lawsuit, we may share your information if we get a court order to do so. This includes subpoenas, requests for information or other legal actions.

Inmates. If you, or your child, are an inmate of a jail or prison or in the custody of a law enforcement official, we may share health information about you or your child with them so that they can give you health care; for the care and safety of you or others; or for the safety and security of the correctional institution.

Other Disclosures. Uses and disclosures other than those described in this notice will be made only with your specific written permission, including any use of your personal health information for marketing purposes or sale. You have the right to revoke this permission.

Your Rights Regarding Your Health Information

Right to See and Copy: You have the right to look at or get a copy of your health information that is in our records. Parents can request to see health information of their child. You may ask for the information in paper or electronic format. We may charge you a reasonable fee for copies of your information. We may deny your request to see or copy your information for only a few reasons. We are not allowed to share psychotherapy notes with you or health information that may be tied to a legal proceeding. If this happens, you can ask that the denial be reviewed. Another professional will be chosen to review your request and we will agree with what they decide about giving you the information.

Right to Know if Information has been Shared: You have the right to get a list of times we gave your health information to someone for reasons other than treatment, payment, or health care operations within the past six years. This excludes information we may have shared with you or your family and friends involved in your care, and the times that we had your signed permission to do so. You must ask us in writing for this list and we may charge you a reasonable fee for any copies.

Right to Restrict Certain Information Released to Health Plans: You have the right to ask us to restrict release of certain health information to a health (insurance) plan for payments or audits when you have paid out of pocket in full for the service.

Right to Ask for Restriction of Your Information: You have the right to ask us to put more restrictions on how your health information is shared for your treatment, payment or quality reviews. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You need to ask for this in writing. You must include in the letter: (1) what information you want us to restrict; (2) whether you want to limit our use of the information, sharing it, or both, and (3) to whom the limits apply

Right to Ask for Other Ways of Getting in Touch with You: You have the right to ask us to get in touch with you about your health in some other way or at some other place. For example, you can ask that we only contact you at work, not home, or by mail not phone. You must ask us to do this in writing and you must tell us how and where you want us to contact you. We will not ask you why.

Right to Ask for Changes: You have the right to ask that we change your health information. You must ask for this change in writing and it must tell why the change is needed. There might be reasons we are not allowed to change some parts of your record. If we deny your request, you have the right to submit a letter of disagreement to us and we will respond back to you.

Electronic Notice: If you receive this notice on our web site, or by e-mail you can also ask for a paper copy.

Breach: You have the right to be notified of any breach of your unsecured protected health information.

Questions and Complaints

Information on our Privacy Practices: Lorain County Public Health (LCPH) has to follow what's in this notice. But, we have the right to change this notice at any time and will provide a copy of any changes by posting them on our web site and in our lobby. If you want more information about our privacy practices or have questions or concerns, please contact us.

Filing a Complaint: If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about using or sharing your health information, you may send us your complaint using the address below. You may also send a written complaint to the US Department of Health and Human Services. We will give you their address if you need. We support your right to protect the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact:
Privacy Officer
Lorain County Public Health
9880 Murray Ridge Rd. Elyria, Ohio 44035
Telephone: 440-322-6367
Website: www.loraincountyhealth.com

Lorain County Public Health
For the Health of Us All

Effective 07/16/15, Revised 11/10/22

Lorain County Public Health
9880 Murray Ridge Road
Elyria, Ohio 44035
440-322-6367 (phone) 440-322-0911 (fax)

ACKNOWLEDGEMENT: NOTICE OF PRIVACY PRACTICES

Name of Patient: _____ Date of Birth: _____/_____/_____

I acknowledge that a copy of Lorain County Public Health's Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, is available to me upon my request. I understand that Lorain County Public Health has the right to change this Notice of Privacy Practices at any time. I may obtain a current copy by contacting the department in which my care was provided or by visiting Lorain County Public Health's website at loraincountyhealth.com.

_____
Signature of Patient/Personal Representative Date

_____
Printed Name

_____
Personal Representative's Title (e.g. Parent, Guardian, Health Care Power of Attorney, etc.)

In addition to all releases mandated by law and/or authorized by policy, I authorize Lorain County Public Health to discuss my protected health information with the following person(s)

Spouse _____ Parent _____

Healthcare Provider(s) _____

Healthcare Provider(s) _____

Other(s) _____

Other(s) _____

_____ (please initial) I authorize Lorain County Public Health to utilize standard mail delivery services for any medical correspondence, including but not limited to, medical forms, plans of care, treatment resources, test results (except HIV and STIs), and immunization records (including Covid 19) that may pertain to the patient listed above. Correspondence will be mailed to the most current address on file at the time of mailing.

_____
Signature of Patient/Personal Representative Date

FOR DEPARTMENT USE ONLY – Complete only if unable to obtain a signature

If the patient or personal representative is unable or unwilling to sign this acknowledgement or the acknowledgement is not signed for any other reason, state the reason below.

_____

_____

Describe steps taken to obtain patient's or personal representative's signature on the acknowledgement.

_____

_____ _____
Signature of Staff Member Date

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HIPAA LIST OF IDENTIFIERS

If any one of the following types of information is being collected from the health records of subjects, or is being collected directly from subjects and the information is linked to the subject's medical record, then HIPAA is applicable (this is not a complete list and is only included for reference and information not listed here may be considered PHI.)

1. Names
2. All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of the zip code if according to the current publicly available data from the Bureau of the Census: a) the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and b) the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
4. Telephone numbers
5. Fax numbers
6. Electronic mail addresses
7. Social security numbers
8. Medical record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URLs)
15. Internet Protocol (IP) address numbers
16. Biometric identifiers, including finger and voice prints
17. Full face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code

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REQUEST FOR AMENDMENT TO PROTECTED HEALTH INFORMATION

Client Name	**Date of Birth**
Street Address	
City/State/Zip	
Home Phone	**Work Phone**

☐ **Correction** ☐ **Addition** ☐ **Date of Entry to be Amended:**

After review of my health information, I feel that the original documentation regarding

_____

is inaccurate because

_____

_____

Therefore, I am hereby requesting that the following amendment be made to my health information and become an approved attachment to my permanent record.

_____

_____

I understand this request applies only to the health information created by this agency and that in order to amend my health information created by another health care provider I must send a separate request to that provider.

_____ _____

Signature of Client or Legal Representative **Date**

_____

If Signed by Legal Representative, Relationship to Client

This Section for Agency Use Only

□ **Request APPROVED**

Agency Requirements
- □ **Attach amendment to all appropriate records**
- □ **Notify Client of approval**
- □ **Notify persons/agencies identified and authorized by Client**

□ **Request DENIED** **Reason for Denial:**
- □ **Information was not created by this agency**
- □ **Information was not part of a designated record set**
- □ **Information is accurate and complete**
- □ **Information is not available to Client per federal law**

Agency Requirements
- □ **Provide written denial notice to Client**
- □ **Inform Client of right to submit Statement of Disagreement**

_____ _____

Employee Signature **Date**

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____ **Date of Birth**: ____/____/_____

I authorize _____ (Name of Agency) to disclose the following information to:

Name of Agency or Provider _____
Address of Agency/Provider _____
Fax Number of Agency _____ Telephone Number _____

Records to be disclosed:
☐Entire medical record

☐Records covering services provided from
_____/_____/_____ to _____/_____/_____
☐All records between these dates
☐Lab tests excluding HIV/AIDS
☐Immunization records
☐Imaging reports
☐HIV/AIDS test results* _____ (initial)
☐Mental health records* _____ (initial)
☐Drug/alcohol diagnosis, treatment, referral information* _____ (initial)
☐Other _____

Reason for disclosure:
☐Requested by Patient/Parent/Guardian
☐ Coordination of care
☐Legal case

***** Additional laws pertaining to the use and disclosure of information related to these types of records may apply. I understand and agree that this information will only be disclosed if I place my ***initials*** in the applicable space next to the type of information.

- I understand that I may revoke this authorization at any time by submitting a written request. I understand that revocation does not apply to information that has already been released in response to this authorization.
- I understand that the party receiving my information might not be subject to HIPAA and might be allowed to disclose this information.
- I understand that authorizing the disclosure of this health information is voluntary, and I can refuse to sign this authorization form. I need not sign this form in order to assure treatment.
- I understand that I may request to inspect or copy the information to be used or disclosed, as provided in 45 C.F.R.164.524.
- I understand that any disclosure of information carries with it the potential for un-authorized re-disclosure and the information may not be protected by federal confidentiality rules.

Expiration Date**:** ____/____/_____ If no date is provided, authorization will expire in 12 months from the date on which it was signed.

Authorized by: _____ **Date:** ____/____/_____

If signed by someone other than the Patient:
Print Full Name_____
Authority to sign: ☐Parent or Guardian
☐Appointed by Patient as HIPAA Personal Representative
☐Other _____

Notice to Recipient: Any disclosure of HIV/AIDS Test results are confidential and are protected from further disclosure by state law. **You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains**, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

For Staff Use Only: Name of Staff Person completing disclosure request _____

☐Identification verified. Form of ID used: _____
☐Copy of signed authorization given to Patient/Parent/Guardian
☐Copy of records released given to Patient/Parent/Guardian (if requested)
☐Revocation received on____/____/_____ and acted upon.

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ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Client Name				**Date of Birth**
Date of Disclosure	**Name and Address of Entity Receiving Protected Health Information**	**Brief Description of Protected Health Information**	**Purpose of the Disclosure (or attach copy of written request)**	**Employee Signature**

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REQUEST FOR ACCOUNTING OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name	**Date of Birth**
Street Address	
City/State/Zip	
Home Phone	**Work Phone**

Request of Accounting

I hereby request an accounting of the disclosure of my health information from this agency's designated record set(s) that was made to persons/agencies outside of the agency from _____to _____ (not to exceed a six (6) year period of time). I understand that this accounting shall not include the following disclosures:

- ☐ To me/my personal representative/other persons involved in my care,
- ☐ To carry out treatment, payment, and health care operations,
- ☐ Other Disclosures allowed as outlined in our Notice of Privacy Practices,
- ☐ Disclosures that occurred prior to April 14, 2003

_____ _____
Signature of Client or Legal Representative **Date**

_____
If Signed by Legal Representative, Relationship to Client

This Section for Agency Use Only

☐ **Request APPROVED**
Agency Requirements: ☐ Provide Client with copy of Accounting of Disclosure form
☐ Ensure disclosures were made after 4-14-03

☐ **Request DENIED**
Reason for Denial: ☐ No disclosures recorded
☐ Time period specified by Client was prior to 4-14-03

☐ **Request WITHDRAWN**

_____ _____
Employee Signature **Date**

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INVESTIGATION OF POTENTIAL PRIVACY BREACH

Client's Name: _____ Date: _____

Investigator: _____

Description of Event:

Who obtained access to PHI: _____

Were they authorized to do so? _____

If not authorized, how did they gain access?

Risk Assessment:

Does the disclosure pose a significant risk of financial, reputational or other harm to client?
☐ YES ☐ NO

If yes, explain how:

How many clients' information was disclosed? _____

Was the disclosure unintentional or accidental? _____

Was the disclosure a "one time" event, or is there a risk the same information could be used or disclosed to someone else? _____

Did the person who received the information keep a copy, or did they just see the PHI in our records?
_____

If the PHI is in electronic form, is the information encrypted, and was the disclosure in an encrypted form?
_____

Findings discussed with Director of Administrative Services or designee on: _____

Did a breach (as defined) occur? ☐ YES ☐ NO

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Explain:

Remedial steps taken:

Notice sent to client(s) on: _____

Did breach involve PHI for more than 500 clients? ☐ **YES** ☐ **NO**

If yes, date media was contacted: _____

Date of notification to Secretary of DHHS: _____

Retain copies of all Notices provided to client, media and Secretary.

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BUSINESS ASSOCIATE AGREEMENT FOR LORAIN COUNTY PUBLIC HEALTH

This Business Associate Agreement is made and entered into as of the _____day of _____, 20____, **("the Effective Date")** by and between the Lorain County Public Health located at 9880 Murray Ridge Road, Elyria, OH 44035 and _____, (an individual/corporation/professional corporation/limited liability company) **("Business Associate"),** located at _____.

RECITALS

A. Business Associate provides certain services to LCPH and, in connection with those services, LCPH discloses to Business Associate or Business Associate receives on behalf of LCPH certain individually identifiable protected health information ("PHI") that is subject to protection under the federal health care privacy regulations. 45 CFR §§ 160 and 164, as may be amended from time to time (the "Privacy Regulations"), of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); and the Security Standards issued thereunder;

B. The parties further wish to protect information as required by the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA)(Pub. L. 111-5); and

C. The parties desire to comply with the Privacy Regulations and Security Standards for the purpose of protecting and ensuring the privacy and confidentiality of PHI belonging to clients of LCPH.

NOW THEREFORE, for and in consideration of the recitals above and the mutual covenants and conditions herein contained, LCPH and Business Associate enter into this Agreement to provide a full statement of their respective responsibilities.

SECTION I: DEFINITIONS

1.1 Definitions. Unless otherwise provided herein, terms contained in this Agreement shall have the same meaning as set forth in the Privacy Regulations.

SECTION II: SCOPE AND USE OF PHI

2.1 Compliance Plan. Business Associate represents that it has adopted a HIPAA Compliance Plan, which includes the requirements of HITECH, will be responsible for the training of its employees and agents regarding compliance and will maintain complete records regarding its compliance with the Privacy Regulations and the terms of this Agreement.

2.2 Performance of Agreement. Business Associate, its agents and employees (collectively referred to as "Business Associate") may use PHI solely to perform its duties for LCPH and only as allowed by the terms of this Agreement and the agreement for services to be performed for LCPH ("Underlying Agreement"). Business Associate agrees that it will not use or disclose PHI in a manner that violates the Privacy Regulations.

2.3 Safeguards for Protection of PHI. Business Associate agrees that it:
(a) Will protect and safeguard from any oral and written disclosure, all PHI regardless of the type of media on which it is stored (e.g., computer software, paper, fiche, etc.) with which it may come into contact in accordance with applicable statutes and regulations, including, but not limited to the Privacy Regulations and Security Standards.
(b) Implement and maintain appropriate policies and procedures to protect and safeguard PHI, and
(c) Use appropriate safeguards to prevent use and disclosure of PHI other than as permitted by this Agreement or as required by law. Business Associate acknowledges that LCPH is relying on the assurances of Business Associate that Business Associate will comply with all applicable laws and regulations, including but not limited to the Privacy Regulations and HIPAA. Business Associate shall promptly notify Practice of any material change to any aspect of its safeguards.

2.4 Investigation. In the event the Business Associate or its subcontractors or agents determine that a potential access or disclosure of PHI has occurred, contrary to the Privacy Regulations, Business Associate will immediately investigate the incident, conduct a risk assessment, and document its findings. In the event that after the investigation, Business Associate determines that a breach has occurred which does not meet an exception, then and in such event, Business Associate will report that finding to LCPH as soon as possible, but no later than 30 days after the discovery of the incident. Business Associate and LCPH will jointly determine the nature and form of the notification to the media or the Secretary of Health and Human Services.

2.5 Costs. In the event that a breach has occurred, the parties agree that the cost associated with notification, compliance and the like, related to breaches under the control of Business Associate, will be at the cost and expense of Business Associate. Business Associate will hold LCPH harmless from and against any and all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including but not limited to attorney's fees, expert witness fees, cost of investigation, litigation or dispute resolution related to or arising out of or in any manner connected with the improper disclosure or breach by Business Associate or its agents of any PHI.

2.6 Use of Subcontractors or Agents. To the extent Business Associate uses one or more subcontractors or agents to provide services under the Underlying Agreement, and such subcontractors or agents receive or have access to PHI, Business Associate shall indemnify and hold LCPH harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including but not limited to attorney fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of or in any manner connected with the improper disclosure of PHI by the subcontractor or agent utilized by Business Associate.

2.7 Breach or Misuse of PHI. Business Associate recognizes that any breach of the terms of this Agreement may give LCPH the immediate right to terminate this Agreement, the Underlying Agreement and/or pursue other available legal action.

SECTION III: AMENDMENT OF PHI

3.1 Amendments Requested by LCPH Business Associate shall promptly incorporate all amendments or corrections to PHI when notified by LCPH that such information is inaccurate or incomplete.

Lorain County Public Health
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SECTION IV: SECURITY STANDARDS

4.1 **Security Standards.** Business Associate represents that it has adopted policies and procedures to implement the Security Standards under the Regulations, which does include protection steps to:

(1) Ensure the confidentiality, integrity and availability of all electronic PHI received or transmitted to or from Business Associate by LCPH;
(2) Protect against any reasonably anticipated threats for hazards to the security or integrity of PHI that are not otherwise permitted by the Privacy Regulations; and
(3) Ensure compliance with these policies by its employees and agents.

SECTION V: AUTOMATIC CHANGES AND UPDATES TO THIS AGREEMENT

5.1 **HITECH**. The parties acknowledge that HITECH includes some modifications of the Privacy Regulations and creates additional obligations of parties who possess PHI. This agreement is written to comply with the revision enacted in the HITECH statue in February 2009, the regulation changes published in August 2009 and further updates published January 25, 2013.

The parties acknowledge that this Agreement shall automatically change to incorporate any changes in the Privacy Regulations as required by HITECH that go into effect in the future, and that each party shall be exclusively responsible for updating their own policies and procedures, training staff, and taking additional steps to fully comply with any future changes in requirements announced by the DHHS in the future.

5.2 Although not exclusive and other changes may be required, the parties acknowledge at this time DHHS has indicated changes will be required in the areas of

(a) Compliance with patient requested restrictions on disclosure of specific health care items for which payments have been made in cash;
(b) The requirements to return or destroy PHI under certain circumstances;
(c) Compliance with the new “minimum necessary” criteria;
(d) Compliance with the new accounting of disclosures of PHI through electronic health records;
(e) Providing access to PHI in electronic format upon request;
(f) Prohibition of the sale or use of PHI for marketing purposes; and
(g) Procedures to monitor and cooperate in audits by DHHS upon request by Department.

5.3 The parties acknowledge that this agreement shall automatically be updated to require each party to fully comply with the then current version of the rules and regulations as modified from time to time without the necessity of changing this Agreement in writing.

SECTION VI: AVAILABILITY, AUDITS AND INSPECTIONS

6.1 **Availability of PHI.** Business Associate agrees that it will: (a) make available PHI in accordance with 45 CFR § 164.524; and (b) make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528. Business Associate will provide such accounting to LCPH as soon as possible, but at most within twenty (20) days from the date of request by LCPH. Each accounting shall provide:

(i) the date of each disclosure;
(ii) the name and address of the organization or person who received the PHI;
(iii) a brief description of the information disclosed; and

(iv) for disclosures other than those made at the request of the subject, the purpose for which the information was disclosed and a copy of the request or authorization for disclosure. Business Associate shall maintain a process to provide this accounting of disclosures for as long as Business Associate maintains PHI received from or on behalf of LCPH.

6.2 Access to The Department of Health and Human Services. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by one party on behalf of the other, available to the Secretary of the Department of Health and Human Services, governmental officers and agencies for purposes of determining compliance with 45 CFR §§ 164.500-534.

SECTION VII: TERM AND TERMINATION

7.1 Term. This Agreement shall commence on the Effective Date and will remain effective until terminated ("Term").

7.2 Termination for Improper Use. LCPH may immediately terminate this Agreement by written notice if LCPH, in its sole discretion, reasonably suspects that Business Associate has improperly used or disclosed PHI in breach of this Agreement.

7.3 Termination for Inadequate Safeguards. LCPH may immediately terminate this Agreement in writing without penalty if it determines, in its sole discretion, that any of Business Associate's safeguards are unsatisfactory for the protection of PHI.

7.4 Termination after Repeated Violations. LCPH may terminate this Agreement by written notice if Business Associate repeatedly violates this Agreement or any provision hereof, irrespective of whether, or how promptly, Business Associate may remedy such violation after being notified of the same. In the event of such termination, LCPH shall not be liable for the payment of any services performed by Business Associate after the effective date of termination.

7.5 Termination of Underlying Agreement. This Agreement will immediately terminate without notice upon termination of the business relationship between the parties.

7.6 Return/Destruction of PHI. Business Associate agrees that, the Business Associate upon termination of this Agreement, for whatever reason, will return or destroy all PHI received from, or created or received by the Business Associate, on behalf of LCPH, regardless of form.

7.7 No Feasible Return/Destruction of PHI. To the extent such return or destruction of PHI is not feasible, Business Associate shall extend the precautions of this Agreement to the retained information. Business Associate shall remain bound by the provisions of this until such time as all PHI has been returned or otherwise destroyed.

7.8 Effect of Termination. All rights, duties and obligations established in this Agreement shall survive termination of this Agreement.

SECTION VIII: INDEMNIFICATION AND INSURANCE

8.1 Indemnification. Business Associate shall indemnify and hold LCPH harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses,

of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement by Business Associate, and its agents and subcontractors.

SECTION IX: DISCLAIMER

9.1 Disclaimer. LCPH MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY BUSINESS ASSOCIATE WITH THIS AGREEMENT OR THE PRIVACY REGULATIONS WILL BE ADEQUATE OR SATISFACTORY FOR BUSINESS ASSOCIATE'S OWN PURPOSES OR THAT ANY INFORMATION IN THE POSSESSION OR CONTROL OF BUSINESS ASSOCIATE, OR TRANSMITTED OR RECEIVED BY BUSINESS ASSOCIATE, IS OR WILL BE SECURE FROM UNAUTHORIZED USE OR DISCLOSURE, NOR SHALL LCPH BE LIABLE TO BUSINESS ASSOCIATE FOR ANY CLAIM, LOSS OR DAMAGE RELATING TO THE UNAUTHORIZED USE OR DISCLOSURE OF ANY INFORMATION RECEIVED BY BUSINESS ASSOCIATE FROM LCPH OR FROM ANY OTHER SOURCE. BUSINESS ASSOCIATE IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY BUSINESS ASSOCIATE REGARDING THE SAFEGUARDING OF PHI.

SECTION X: MISCELLANEOUS

10.1 Construction. This Agreement shall be construed as broadly as necessary to implement and comply with the Privacy Regulations, Security Standards, and HITECH. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with the Privacy Regulations.

10.2 Notice. All notices and other communications required or permitted pursuant to this Agreement shall be in writing, addressed to the party at the address set forth at the end of this Agreement, or to such other address as either party may designate from time to time. All notices and other communications shall be mailed by registered or certified mail, return receipt requested, postage pre-paid, or transmitted by hand delivery. All notices shall be effective as of the date of hand delivery or on the date of receipt, whichever is applicable.

10.3 Modification of Agreement. The parties recognize that this Agreement shall automatically be modified to account for any changes in Privacy Regulations, Security Standards or HITECH without the necessity of a written amendment. In the event that either party objects to any such automatic amendment, they shall be required to notify the other party immediately in writing as to such changes which they do not agree to and the other party shall have 20 days to respond to such notice. In the event the parties cannot reach an agreement regarding such items, this Agreement will automatically terminate.

10.4 Transferability. LCPH has entered into this Agreement in specific reliance on the expertise and qualifications of Business Associate. Consequently, Business Associate's interest under this Agreement may not be transferred or assigned or assumed by any other person, in whole or in part, without the prior written consent of LCPH.

10.5 Governing Law and Venue. This Agreement shall be governed by, and interpreted in accordance with, the laws of the State of Ohio, without giving effect to its conflict of law's provisions.

10.6 Binding Effect. This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective permitted successors and assigns. In the event of the termination of this Agreement, each of the parties acknowledges the ongoing responsibility to maintain the security and privacy of PHI.

10.7 Execution. This Agreement may be executed in multiple counterparts, each of which shall constitute an original and all of which shall constitute but one Agreement.

10.8 Gender and Number. The use of the masculine, feminine or neuter genders, and the use of the singular and plural, shall not be given an effect of any exclusion or limitation herein. The use of the word "person" or "party" shall mean and include any individual, trust, corporation, partnership or other entity.

10.9 Severability. In the event that any provision or part of this Agreement is found to be totally or partially invalid, illegal, or unenforceable, then the provision will be deemed to be modified or restricted to the extent and in the manner necessary to make it valid, legal, or enforceable, or it will be excised without affecting any other provision of this Agreement with the parties agreeing that the remaining provisions are to be deemed to be in full force and effect as if they had been executed by both parties subsequent to the expungement of the invalid provision.

10.10 Waiver. The failure of either party to this Agreement to insist upon the performance of any of the terms and conditions of this Agreement, or the waiver of any breach of any of the terms and conditions of this Agreement, shall not be construed as thereafter waiving any such terms and conditions, but the same shall continue and remain in full force and effect as if no such forbearance or waiver had occurred.

10.11 Priority of Agreement. If any portion of this Agreement is inconsistent with the terms of the Underlying Agreement, the terms of this Agreement shall prevail. Except as set forth above, the remaining provisions of the Underlying Agreement are ratified in their entirety.

10.12 Heading. The headings of Articles and Sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

10.13 Entire Agreement. This Agreement constitutes the entire agreement between the parties with respect to the matters contemplated herein and supersedes all previous and contemporaneous oral and written negotiations, commitments, and understandings related thereto.
IN WITNESS WHEREOF, LCPH, by and through its duly authorized officer, and Business Associate have caused this Agreement to be executed on the day and year set forth previously.

Lorain County Public Health
9880 Murray Ridge Road
Elyria, Ohio 44035
440-322-6367 (phone) 440-322-0911 (fax)

LCPH:
Lorain County Public Health

By: _____

Name: _____

Title: _____

Address for Notice:
9880 Murray Ridge Road, Elyria, OH 44035

BUSINESS ASSOCIATE:
Name of Business Associate:

_____

By: _____

Name: _____

Title: _____

Address for Notice:
_____

_____