Summary Guidelines for Safeguarding the Privacy of Health Information

These are guidelines centered on how to safeguard health information and ensure confidentiality when using normal business communications, such as conversations, telephone, faxes, mail, and electronic mail. Wherever practical, the material containing Protected Health Information (PHI) should be labeled as confidential on the document, diskette, CD, or other medium. PHI maintained electronically should be password-protected in all media.

Also when using and disclosing PHI, you must take reasonable measures to ensure the information is protected. Below are simple safeguarding tasks that should be used when communicating in a work environment that necessitates access to and use and disclosure of PHI. Remember to limit your communications of PHI to the minimum necessary for the intended purpose. Restrict your communications to those who have a valid "need to know" the information. If you have questions about these safeguards and how to protect PHI communications, please discuss them with your supervisor.

Oral Conversations – in person

- □ Discuss participants PHI in private. Use an office with a door whenever possible, or leave areas where others can overhear.
- □ Be aware of those around you and lower your voice when discussing participants health information.
- □ If possible, point out health information on paper or on-screen non-verbally when discussing participants health information.

Oral Conversations - telephone

- □ Follow the above guidelines for "Oral Conversations"-in person"
- □ Don't use names instead say; "I have a question about a client".
- □ Never give PHI over the phone when talking to unknown callers, but call back and verify information.
- □ Never leave PHI on voice messages; instead leave a message requesting a return call to discuss a participant giving only your name and phone number.
- □ Do not discuss PHI over unencrypted cellular or portable (wireless) phones or in an emergency, as the transmissions can be intercepted.

Fax

- □ Put fax machines in a safe location, not out in the open or in a public or area with high-traffic or easy access and visibility.
- □ Use a cover sheet clearly identifying the intended recipient and include your name and contact information on the cover sheet.
- □ Include a confidentiality statement on the cover sheet of faxes that contain PHI.
- □ Do not include or reference PHI on cover sheet.
- □ Confirm fax number is correct before sending.
- □ Send fax containing participant health information only when the authorized recipient is there to receive it whenever possible.
- □ Verify that fax was received by authorized recipient; check the transmission report to ensure correct number was reached and when necessary contact the authorized recipient to confirm receipt.
- □ Deliver received faxes to recipient as soon as possible. Do not leave faxes unattended at fax machine.

Email

- □ Do not include PHI in Subject-line or in Body of email.
- □ Transmit PHI only in a password-protected attachment (MS Word and MS Excel provide password protection).
- □ Include a confidentiality statement on emails that contain any PHI in email attachments.
- □ Do not send attachment passwords in the same email as the attachment.
- □ Include your contact information (name and phone number minimum) as part of the email.
- □ Set email sending options to request an automatic return receipt from your recipient(s).
- □ Request that email recipients call to discuss specific participant data.
- □ Do not store emails or email attachments with PHI on your hard drive but copy and store to a secure server. Delete the email and the attachments when they are no longer needed.

Courier and Regular Mail

- □ Use sealed secured envelopes to send PHI.
- □ Verify that the authorized person has received the package.
- □ Deliver all mail promptly to the recipient.
- □ Mailboxes must be in safe areas and not located in public or high-traffic areas.

Inter-Office Mail

- □ Put PHI in closed inter-office envelopes. As an added precaution, put PHI in a sealed envelope inside the inter-office envelope.
- □ Identify recipient by name and verify mail center address.
- □ Distribute inter-office mail promptly to recipients. Do not leave unattended in mailboxes.
- □ Where practical, use lockable containers (e.g. attaches) to transmit correspondence that contains participant PHI.

Computer Workstations

- □ Use password protected screen savers, turn off the computer, or log out of the network when not at your desk.
- □ Position screens so they are not visible to others.
- □ Secure workstations and laptops with password.
- □ Change passwords on a regular basis.
- □ Do not leave laptop or work-related participant PHI visible or unsecured in a car, home office, or in any public areas.
- □ Ensure that all PHI used outside work premises is protected using appropriate measures such as locked desks, file cabinets.
- □ Never remove original copies of PHI from the agency without your supervisor's approval for specific purposes.
- □ Store files that contain PHI on a secure server, not on your workstation hard drive.

Disposal of PHI

- □ Shred all hard copies containing PHI when the copies are no longer needed.
- □ Place hardcopies to be recycled in locked recycle bins if available.
- □ Delete all soft copy files containing PHI from your computer and from the server when the information is no longer needed within the record retention requirements.
- □ Destroy all disks, CDs, etc., that contained PHI before disposing them.
- □ Do not reuse disks, CDs that contained PHI without sanitizing them first.
- □ Contact IT before transporting or transferring equipment for proper procedures to move equipment and to sanitize hard drives and other media.
- □ Return the PHI to the sender, if this requirement is stipulated in any contractual agreements.

Work Areas

- □ Do not leave PHI (files, records, Rolodex, reports) exposed, open, or unattended in public areas, conference rooms, mailboxes, wall trays, etc.
- □ Store all PHI securely in locked file cabinets, desk drawers, offices, or suites when you are not in your work area.

USANOTIFY
ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (732) 290-1900.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. USANOTIFY provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The participant understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- USANOTIFY has a Notice of Privacy Practices and that the participant has the opportunity to review this notice.
- USANOTIFY reserves the right to change the Notice of Privacy Practices.
- The participant has the right to request restrictions to the uses of their information but USANOTIFY does not have to agree to those restrictions.
- The participant may revoke this Consent in writing at any time and full disclosures will then cease.
- USANOTIFY may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

____

Name of Participant (print)

____________________________________ ______________

Signature of Participant Date

____________________________________ ______________

Signature of Participant Representative Date

(Required if participant is a minor or an adult who is unable to sign this form)

____

Relationship of Participant Representative to Participant Print Name

USANOTIFY
Authorization for Release and/or Disclosure of Health Information

I authorize the disclosure of my personal health information to the persons/entities as described below. I understand this authorization is voluntary, and made to confirm my directions. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations. I hereby give permission to USANOTIFY to disclose my personal health information in the manner described herein.

PARTICIPANT'S INFORMATION		
Name:	Medical Record #:	
Birth Date:	Contact Phone Number:	Request Date:
PHI MAY BE DISCLOSED BY:		
Person/Facility:	Phone #:	
	Fax #:	
Address:		
PHI MAY BE DISCLOSED BY:		
Person/Facility:	Phone #:	
	Fax #:	
Address:		

PERSONAL HEALTH INFORMATION TO BE DISCLOSED

1. Specify records to be released and/ or disclosed:

- □ General Medical Information (from_____________ to ________________)
- □ Information Regarding Specific Injury or Treatment (from ________________ to ___________________)
- □ X-Ray/Laboratory Results of (from ______________ to ___________________)
- □ Mental Health (from ______________ to ________________) Initials of Participant or Representative _______________
- □ Alcohol/Drug (from ___________________ to _____________) Initials of Participant or Representative _______________
- □ HIV Test Results (from ______________ to ___________) Initials of Participant or Representative _______________
- □ Other (specify): ____

2. Your request will be deemed to include any information related to sexually transmitted disease, alcohol or drug use or treatment, or mental health/psychology/psychiatry that may be within your above request, unless you specifically state your objection here:

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that occurred before USANOTIFY received and processed a written notice of revocation. I understand that if I did not specify duration and if I do not revoke it, this authorization will expire one year from the date of signature below. To revoke this authorization, I understand that I must send a written request to USANOTIFY, ATTN: Privacy Officer, 1230 Hwy 34, Aberdeen, NJ 07747.

ACKNOWLEDGEMENT

Please sign and date: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to USANOTIFY to release nonpublic personal health information. I understand that USANOTIFY will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

By: ____ ______________________________________ __________

Participant's Name (Print) Participant's Signature Date

If you are not the participant, please also complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof or your relationship tot the participant (e.g. Power of Attorney, legal guardian)

By: ____ ______________________________________ __________

Participant's Name (Print) Participant's Signature Date

□ Parent of Minor Child □ Legal Guardian □ Power of Attorney □ Executor □ Other __________________________

USANOTIFY
Request for Alternative Means of Communication of Protected Health Information

Use this form to request that you receive communications of protected health information (PHI) by alternative means, or at an alternate location.

Completing this form is voluntary. However, if you would like alternative means of communication of your protected health information, you must provide all of the information requested on this form. Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

INSTRUCTIONS: Mail or hand deliver this completed form to the following address: USANOTIFY, ATTN: Privacy Officer, 1230 Hwy 34, Aberdeen, NJ 07747

INDIVIDUAL'S INFORMATION		
Name:	Medical Record # or ID#:	
Birth Date:	Contact Phone Number:	Request Date:
Current Address (No., street, city, state, zip):		

Please read and complete the following:
At USANOTIFY, we may mail communications containing your PHI to the subscriber (the person receiving the benefits). Communications are addressed to your address as listed in our medical records. We also rely upon telephone information in your medical records when we contact you by telephone. If you believe this method of communication could endanger you, you have the right to request that we:

- Use a reasonable alternate means for communicating your PHI
- Send your PHI to an alternate address
- Contact you at an alternate phone number

Please note that we are not able to accommodate requests for communications to alternate addresses made solely for reasons of convenience.

ALTERNATIVE MEANS OF COMMUNICATION
I request that USANOTIFY communicate with me about my PHI by alternate means, to send such communications to an alternate address, and/or to contact me at an alternate phone number. (Please provide full information regarding the alternate means, address, phone number, etc. that you want us to use.)
I hereby request that any future communications to me from USANOTIFY regarding my health information be directed through alternate methods or means as follows: □ Alternative Phone Number: (____)____ □ Alternative Mailing Address: (____)____ □ Other Alternative Means: ____ ____ □ State any harm that may occur if this request is denied: ____________________________ ____

ACKNOWLEDGEMENT. Please read, sign and date:

I have read the above statements and understand that USANOTIFY is not required to agree to every accommodation request, but only required to attempt to accommodate reasonable request when appropriate.

By: ______________________________________ ______________________________________ _________

Participant's Name (Print) Participant's Signature Date

If you are not the participant, please also complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof or your relationship tot the participant (e.g. Power of Attorney, legal guardian)

By: ____ ____ _________

Participant's Name (Print) Participant's Signature Date

□Parent of Minor Child □Legal Guardian □Power of Attorney □Executor □Other __________________________

<u>This Section for Company Use Only</u>

□ **Request APPROVED**
Return a copy of completed form to individual. Send original to Medical Records to make amendment and place in individuals file. Send change to Business Associate(s) as needed

□ Request DENIED
Reason for Denial:
- ❑ Too expensive to accommodate request
- ❑ Administratively impractical to accommodate request
- ❑ Failure of Participant to specify an alternative accommodation

Send a copy of completed form to individual. Send original to Medical Records to place in individuals Medical Records file.
Date copy sent: ____________________________ Copy sent by (print name): ________________________________

USANOTIFY
Request for Accessing/Inspecting/Copying Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request the opportunity to inspect and copy health information that pertains to you. USANOTIFY will evaluate your request and will either grant it or explain the reason why the request will not be granted. USANOTIFY may provide you with a summary or explanation of the information in your health plan records instead of access to or copies of your records. Mail or hand deliver this completed form to: USANOTIFY, ATTN: Privacy Officer, 1230 Hwy 34, Aberdeen, NJ 07747

INDIVIDUAL'S INFORMATION		
Name:	Medical Record # or ID#:	
Birth Date:	Contact Phone Number:	Request Date:
Current Address (No., street, city, state, zip):		

REQUEST TO ACCESS/INSPECT/COPY

I am requesting my health information in the following designated record set(s) for the period of time from

_________________________ to ________________________:

❑ Medical Records ❑ laboratory Reports ❑ Financial Records
❑ Enrollment, payment, claims adjudication information maintained by USANotify
❑ Other agency designated record sets: ___________________________________

DELIVERY METHOD

Please check the box indicating how you would like to receive the requested health records.

□ **mail to my current address:**

____
street address city state zip code

□ Pick-up (you will be required to provide photo identification.) Please provide a phone number where we may contact you when copies are ready for pick up. _________________________________

□ Review in person (you will be required to provide photo identification.) Any review of participant records will be conducted in the presence of a clinical staff member. Please provide a phone number where we may contact you to schedule an appointment.

Phone number: ____

ACKNOWLEDGEMENT

Please sign and date: I understand that I may be charged a reasonable cost-based fee for copying my records. Applicable mailing fees also may apply. With certain exceptions, you have the right to inspect or obtain a copy of your health information in a designated record set maintained by USANOTIFY. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative action or proceedings and records that are subject to the Privacy Act, 5U.S.C. 522a.

I further understand there may be circumstances when a licensed health care professional may deny my request for access to my health information; and that I am allowed to request a review by another licensed health care professional.

By: ____ _______________________________________ _________
Participant's Name (Print) Participant's Signature Date

If you are not the participant, please complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof or your relationship to the participant (e.g. Power of Attorney, legal guardian)

By: ____ _______________________________________ _________
Participant's Name (Print) Participant's Signature Date

□**Parent of Minor Child** □**Legal Guardian** □**Power of Attorney** □**Executor** □**Other** __________________________

Request Determination on Reverse Side

This Section for Company Use Only

Determination:

□ **REQUEST APPROVED.** Approved date:____

Agency Responsibilities:

□ Determination of method for Participant access. Determination date: _____________________________

□ Notice to Participant of approved access. Sent date: ____

□ Offer Participant summary of information. Sent date: ____

□ Notify Participant of requirements for copies of health information. Sent date: _____________________

Determination:

□ REQUEST NEEDS FURTHER REVIEW

____ ____

Designated Staff Date

Review of Request by Licensed Health Care Professional

Determination:

□ **REQUEST APPROVED.** Approved date:____

Agency Responsibilities:

□ Determination of method for Participant access. Determination date: _____________________________

□ Notice to Participant of approved access. Sent date: ____

□ Offer Participant summary of information. Sent date: ____

□ Notify Participant of requirements for copies of health information. Sent date: _____________________

Determination:

□ **REQUEST DENIED. Denial date:** _________________________________

Reason for Denial:

□ Reference made to another person could endanger that person

□ Access could endanger life or physical safety of Participant or other(s)

□ Access requested by personal representative and access could cause substantial harm to Participant or other(s)

□ Other____

Agency Responsibilities:

□ Written Notice to Participant of basis for denial. Sent date: ______________________________

□ Provide Participant with Opportunity to Request Review by licensed health care professional Sent date: ____

____ _________________________________

Licensed Health Care Professional Date

Request Second Review

Determination:

☐ **REQUEST APPROVED.**

Agency Responsibilities:

☐ Determination of method for Participant access

☐ Notice to Participant of approved access

☐ Offer Participant summary of information

☐ Notify Participant of requirements for copies of health information

Determination:

☐ **REQUEST DENIED.**

Reason for Denial:

☐ Reference made to another person could endanger that person

☐ Access could endanger life or physical safety of Participant or other(s)

☐ Access requested by personal representative and access could cause substantial harm to Participant or other(s)

☐ Other____

Agency Responsibilities:

☐ Written Notice to Participant of basis for denial. Sent date: ____________________________

____ ____________________________

Licensed Health Care Professional Date

USANOTIFY
Request for Amendment of Health Information

As a participant in USANOTIFY's services you have the right to request amendments to your personal health information that are inaccurate or incomplete. If you want to amend your health information, you must complete this form and return it to USANOTIFY, ATTN: Privacy Officer, 1230 Hwy 34, Aberdeen, NJ 07747

If we deny your request, we will let you know in writing with an explanation of why we are denying it. You have the right to submit a written disagreement to our denial. We will put your statement and requested amendment in to your record. If we continue to disagree with your amendment request, we may put a written rebuttal to your disagreement into your record. If this occurs, we will let you know in writing and send you a copy of our rebuttal.

INDIVIDUAL'S INFORMATION		
Name:	Medical Record # or ID#:	
Birth Date:	Contact Phone Number:	Request Date:
Current Address (No., street, city, state, zip):		

REQUESTED AMENDMENT

1. Date(s) of Entry to be amended/corrected: ____

2. Type(s) of Entry to be amended/corrected: ____

3. Please explain how the entry(s) is incorrect or incomplete:

4. What should the entry(s) say in order to be accurate or complete:

5. Would you like this amendment sent to anyone to whom we may have disclosed information to in the past? □NO □YES

If so, please specify the name and address of the organization or individual:

ACKNOWLEDGEMENT
Please sign and date:

By: ______________________________ ______________________________ __________

Participant's Name (Print) Participant's Signature Date

If you are not the participant, please complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof or your relationship to the participant (e.g. Power of Attorney, legal guardian)

By: ______________________________ ______________________________ __________

Participant's Name (Print) Participant's Signature Date

□Parent of Minor Child □Legal Guardian □Power of Attorney □Executor □Other ____________________

This Section for Company Use Only

Amendment has been: � Accepted � Denied (If denied, check the reason for denial):

- □ **PHI (Protected Health Information) was not created by this Organization**
- □ **PHI is not part of the participant's designed record set**
- □ **Federal/State law forbids making corrections to this PHI**
- □ **PHI is accurate and complete**

Comments of Provider:

Amendment has been reviewed by the following Provider(S):

______________________	______________________________	_____________________________________
Date	**Please Print Name**	**Signature of Provider**
______________________	______________________________	_____________________________________
Date	**Please Print Name**	**Signature of Provider**

Notification was sent to the Participant on: _________________________________
Date

Send a copy of completed form to individual. Send original to Medical Records to place in individuals Medical Records file.

Date copy sent: ___________________________ Copy sent by (print name): ___________________________________

USANOTIFY
Request for Restrictions on Use and Disclosure of Health Information

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this request for restriction in whole or in part, but if we do, we are bound by our agreement. Any restriction we accept will not apply when the restricted information is needed to provide you with emergency treatment. This agreement does not apply if release is required by law or if it's against any public health requirements. We further have the right to terminate any agreed upon restriction by informing you of the termination in writing. Any such termination will only apply to information created or received after we have informed you of the termination.

Please complete this form to request a restriction and return it to USANOTIFY, ATTN: Privacy Officer, 1230 Hwy 34, Aberdeen, NJ 07747. We will notify you of our ability to comply with your request by returning a copy of this form to you. You also have the right to request us to terminate a restriction to the extent that such termination applies to information created or received after the date of termination.

INDIVIDUAL'S INFORMATION		
Name:	Medical Record # or ID#:	
Birth Date:	Contact Phone Number:	Request Date:
Current Address (No., street, city, state, zip):		

RESTRICTIONS REQUESTED
1. I would like use and disclosure of the following health information to be restricted:
2. I want the information restricted because:
Check the box that tells how you want this information to be restricted and complete the blank:
□ I do not want this information to be given to the following person(s) or agency(s):
□ Other restrictions requested:

ACKNOWLEDGEMENT
Please sign and date:

By: ______________________________ ______________________________ __________
Participant's Name (Print) Participant's Signature Date

If you are not the participant, please complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof or your relationship to the participant (e.g. Power of Attorney, legal guardian)

By: ______________________________ ______________________________ __________
Participant's Name (Print) Participant's Signature Date

□**Parent of Minor Child** □**Legal Guardian** □**Power of Attorney** □**Executor** □**Other** ________________________

This Section for Company Use Only

Request has been: � Accepted � Denied (If denied, check the reason for denial):

Comments of Provider:

Restriction Request has been reviewed by the following Provider(s):

______________________	____________________________	__________________________________
Date	**Please Print Name**	**Signature of Provider**
______________________	____________________________	__________________________________
Date	**Please Print Name**	**Signature of Provider**

Notification was sent to the Participant on: ________________________________
Date

Send a copy of completed form to individual. Send original to Medical Records to place in individuals Medical Records file.
Date copy sent: ___________________________ Copy sent by (print name): ___________________________________

USANOTIFY
Accounting of Non-Authorized Use or Disclosure Request Form

The HIPAA Privacy Regulations allow an individual to request an accounting of certain disclosures of his/her Protected Health Information (PHI). USANOTIFY may disclose your PHI for treatment, payment, health care operations, and as required or permitted by the HIPAA Privacy Regulation or other state or federal laws. Our Privacy Notice informs you that these disclosures may occur without your consent at the time they are made.

You can request an accounting of certain disclosures only about yourself, unless you are authorized to obtain information about another individual. Please complete this form to request a disclosure and return it to USANOTIFY, ATTN: Privacy Officer, 1230 Hwy 34, Aberdeen, NJ 07747.

INDIVIDUAL'S INFORMATION		
Name:	Medical Record # or ID#:	
Birth Date:	Contact Phone Number:	Request Date:
Current Address (No., street, city, state, zip):		

DISCLOSURE REQUESTED

I request that USANOTIFY provide me with an accounting of any and all applicable "non-authorized" uses and disclosures of my protected health information (PHI) between _______________ (beginning date) and ____________________(ending date).

I would like to limit this request for accounting to include disclosures only pertaining to:

____

I want the accounting of disclosures in the following form: *(check one)*

□ Mail to my current address on file: ____

□ I want to pick up the accounting.
Please call me at the following telephone number when it is ready: ____________________________________

I understand that I may be charged for this information if I have previously requested this information within the last 12 months. There will be a fee for any additional accountings within the same 12 month period. I will be informed of the cost for such additional accounting in advance and will be provided with the opportunity to withdraw or modify the request in order to reduce or avoid the fee. I understand that USANOTIFY must give me the accounting of disclosures within 60 days, or must tell me that it needs up to 30 extra days to prepare it.

I understand that USANOTIFY does not have to tell me about the following types of disclosures:

1. Disclosures made prior to April 14, 2003.
2. Disclosures made as part of a limited data set for purposes of research, public health, or health care operations, as permitted by federal law.
3. Disclosures made for purposes of treatment, payment and health care operations.
4. Disclosures made to me or disclosures consented to or authorized by me.
5. Disclosures made to persons involved in my care.
6. Disclosures made for national security or intelligence purposes.
7. Disclosures made to correctional institutions or law enforcement officials, under certain circumstances.
8. Disclosures made incident to a use or disclosure otherwise permitted or required by law.

I also understand that my right to an accounting of some or all disclosures may be suspended by the government under limited circumstances.

ACKNOWLEDGEMENT
Please sign and date:

By: ______________________________________ ___________________________________ _________
Participant's Name (Print) Participant's Signature Date

If you are not the participant, please complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof or your relationship to the participant (e.g. Power of Attorney, legal guardian)

By: ____ ______________________________________ _________
Participant's Name (Print) Participant's Signature Date

□Parent of Minor Child □Legal Guardian □Power of Attorney □Executor □Other ________________________

Request Determination on Reverse Side

This Section for Company Use Only

Privacy Officer Action/Comments:
Action must be taken within 60 days of the receipt of the request

Request has been: � Accepted � Denied (If denied, please explain):

Comments of Provider:

Restriction Request has been reviewed by the following Provider(s):

____________________	__________________________	________________________________
Date	**Please Print Name**	**Signature of Provider**
____________________	__________________________	________________________________
Date	**Please Print Name**	**Signature of Provider**

Notification was sent to the Participant on: ________________________________
Date

Send a copy of completed form to individual. Send original to Medical Records to place in individuals Medical Records file.
Date copy sent: _________________________ Copy sent by (print name): _________________________________

USANOTIFY INCIDENT REPORT

Date of Incident: _____________________________ Time of Incident: _________________ am/pm

USANotify Location: ____

Person(s) Involved Name: _________________________________ If Participant MR#______________

(Circle one) Participant Staff Volunteer Contractor Other____

Witness(es)____

NATURE OF INCIDENT (check all that apply):

- ○ HIPAA Violation/Breach of Confidentiality
- ○ Complaint/Grievance
- ○ Equipment / Supplies
- ○ Facility Safety and Security
- ○ Inappropriate Behavior
- ○ Injury (specify type)_____________
- ○ Medication error
- ○ Medical Emergency
- ○ Property Damage/TheftOther _________________

Notified: Police Fire Ambulance Licensing Provider____ COO _____ Human Resources _______ Other_______

DETAILS OF INCIDENT (include all known facts, persons involved, statements, cause, witnesses, time, location)

____

____

____

____

____

RESOLUTION (if applicable)

____

____

____

____

REPORTING

Note: Incidents must be reported within 24 hours of occurrence. A copy of this form must be given to department supervisor > COO or HR/Privacy Officer

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Incident Reported to: ____________________________ Title:_______________________________

Date: ________________________

Report completed by: ____Title: ________________________

Date: _____________ Contact Phone number: __________________________ Dept.: _____________

OFFICIAL REVIEW

Incident reviewed by:

- o Quality Assurance Committee
- o Safety Committee
- o Human Resources
- o Medical Director
- o COO
- o Other ____________________________

If applicable, Severity of HIPAA Privacy Incident:

□ Severe — Press may be involved. Affects participant and/or public, business associates, and/or state and/or local government.

□ Moderate — Press involvement unlikely. Affects participant and/or business associates.

□ Low — No affect outside of company. Company able to resolve

COMMENTS BY REVIEWER(S):

____
____
____
____
____
____
____
____
____

RESOLUTION/CORRECTIVE ACTION:

□ Staff Training Needed
□ Inform Participant
□ Procedures to be Reviewed
□ Record disclosure in accounting of disclosures log with Privacy Officer
□ Employee Sanctions
□ Other

____
____
____
____
____
____
____

o No further action required, ok to file

Signature: ___________________________Title:____________________ Date: _________________

THIS IS A CONFIDENTIAL REPORT FOR OFFICIAL USE ONLY. DO NOT FILE IN PARTICIPANT'S RECORD.

USANOTIFY
COMPLAINT REPORT

Today's Date: ________________________

All information can be submitted anonymously, any identifying information is not required.

Name (Optional):	Medical Record #:
Address:	Phone Number:

If you are filing a complaint on someone's behalf, provide the name and address of the person on whose behalf you are filing. Name: ____

Address: ____

Please describe in detail the nature of your complaint, including the date or dates of the incident(s), and the name or names of any USANotify staff member and other witnesses (attach additional sheets if necessary):

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______________________________________ ______________________

Participant or Legal Representatives' Signature Date

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Relationship (if not Participant)

Send to: USANOTIFY Privacy Officer, 1230 Hwy 34, Aberdeen, NJ 07747 (732-290-1900)

For Internal Use Only:

Manager's acknowledgement of receipt Print Name: _________________________________

Date received: ____/____/____

Process of Investigation:

Formal Action Taken/Resolution:

COO or Privacy Office Comments:

COO or Privacy Officer Signature ____

If COO place in QA File, If for Privacy Officer place in HIPAA Log Binder