# HIPAA FORMS

## HIPAA PRIVACY & SECURITY

## ROOSEVELT DENTAL CENTER OF SKAGIT COUNTY

1210 ROOSEVELT AVE
MOUNT VERNON, WASHINGTON 98273

# Roosevelt Dental Center of Skagit County

Mount Vernon, Washington 98273

## HIPAA PRIVACY & SECURITY FORMS

**Statement of Privacy Practices**
- **Short Form**
- **Long Form**

**Acknowledgement of Receipt of "Statement of Privacy Practices"**

### PATIENT RELATED FORMS

Patient Request to Access Protected Health Information
Notice of Decision Regarding Patient's Request to Access PHI
Patient Request to Amend Medical Record
Notice of Decision Regarding Patient's Request to Amend Record
Patient Request for Confidential Communication
Patient Request for Restriction on Use or Disclosure of PHI
Authorization by Patient for Use or Disclosure of Information
Record of Patient Complaint
Patient HIPAA Complaint Log

### EMPLOYEE RELATED FORMS

Employee HIPAA Confidentiality Agreement
Employee HIPAA Training Record
Employee Notice of Disclosure Violation and Reprimand (Sample Letter)
Employee Termination Agreement (Sample Letter)

### BUSINESS ASSOCIATES FORMS

Business Associate Agreement
Exhibit A – Permitted Uses and Disclosures
Exhibit B – Business Associate Verification of Compliance
Obligation to Comply with HIPAA Rules– (Sample Letter)
Business Associate Termination Letter
Visitor Confidentiality Agreement - Professional

### BREACH NOTIFICATION FORMS

Notification to Patient – Breach of Protected Health Information
Notification to Secretary of HHS – Breach of Unsecured Protected Health Information
Documentation of Risk Assessment Associated with Breach of PHI
Business Associate Termination Letter
Service Provider Contact List
Vendor Technical Compliance Statement

### ELECTRONIC SECURITY-RELATED FORMS

Equipment and Media Inventory
EPHI Level Determination Record
Security Threat Evaluation
Security Incident Report
Vendor Visitor Confidentiality Agreement
Vendor Technical Compliance Statement
Service Provider Contact List

# Roosevelt Dental Center of Skagit County

Mount Vernon, Washington 98273

# USER'S GUIDE

## *HIPAA Privacy and Security Programs*

### *PRIVACY – BASIC FORMS*

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|---|---|
| ***TITLE*** | **Statement of Privacy Practices – Short Form** |
| ***Purpose & Use*** | • Supply this form to each new patient as they come to you for medical services<br>• Post a copy of the Statement in an unrestricted area easily accessible to patients to read at their leisure and schedule. |
| ***TITLE*** | **Statement of Privacy Practices – Long Form** |
| ***Purpose & Use*** | • Supply this form to each new patient if the extended version is requested as they come to you for medical services |
| ***TITLE*** | **Acknowledgement of Receipt of Statement of Privacy Practices** |
| ***Purpose & Use*** | • *Acknowledgement:* Each patient must sign, acknowledging receipt of notice<br>• *Additional Disclosure Authority* may be used to get consent from patients to discuss their treatment with others, such as spouses<br>• *Record of Authorization not obtained* may be used to document that the notice you provided to a patient was not acknowledged and returned to you. |

### *PATIENT-RELATED FORMS*

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| ***TITLE*** | **Patient Request to Access Protected Health Information** |
| ***Purpose & Use*** | Use this form to document a patient's request to access or review their records. |
| ***TITLE*** | **Notice of Decision Regarding Patient's Request to Access PHI** |
| ***Purpose & Use*** | Use this form to document and inform patient of your decision regarding their request to access their records |
| ***TITLE*** | **Patient Request to Amend Personal Medical Records** |
| ***Purpose & Use*** | Use this form to document a patient's request to amend or make changes to their personal medical records |
| ***TITLE*** | **Notice of Decision Regarding Patient's Request to Amend Records** |
| ***Purpose & Use*** | Use this form to document a patient's request that certain information only be communicated to them confidentially |
| ***TITLE*** | **Patient Request for Confidential Communication** |
| ***Purpose & Use*** | Use this form to document a patient's request that certain information only be communicated to them confidentially |

# Roosevelt Dental Center of Skagit County

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# USER'S GUIDE

## *HIPAA Privacy and Security Programs*

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| ***TITLE*** | **Patient Request to Place Restriction on Use or Disclosure of Personal Protected Health Information** |
| ***Purpose & Use*** | Use this form to document a patient's request to restrict disclosure of their protected health information |
| ***TITLE*** | **Authorization for Use or Disclosure of Information** |
| ***Purpose & Use*** | Use this form to request a patient's permission to use or disclose the patient's protected health information for purposes other than Treatment, Payment, or Operations (TPO). |
| ***TITLE*** | **Record of Patient Complaint** |
| ***PURPOSE & USE*** | Use this form to document a patient's request to register a complaint concerning your policies and procedures as established under the Health Insurance Portability and Accountability Act. |
| ***TITLE*** | **Patient HIPAA Complaint Log** |
| ***Purpose & Use*** | Use this log as a summary of HIPAA complaints received by patients. ***Note: You must receive the complaint on the PATIENT COMPLAINT form*** |
| | ***EMPLOYEE-RELATED FORMS*** |
| ***TITLE*** | **Employee HIPAA Confidentiality Agreement** |
| ***Purpose & Use*** | Use this form to document that each employee has been trained in your HIPAA policies and procedures and that each employee agrees to abide by the mandates of HIPAA. |
| ***TITLE*** | **Employee HIPAA Training Record** |
| ***Purpose & Use*** | Use this log as a summary of employees trained in HIPAA. ***Note: Each employee must also sign an Employee HIPAA Confidentiality agreement*** |
| ***TITLE*** | **Employee Notice of Disclosure Violation and Reprimand (Letter)** |
| ***Purpose & Use*** | Use this form letter to notify an employee of a violation of the HIPAA Privacy or Security rules, including specifics of the violation and nature of appropriate disciplinary action. |
| ***TITLE*** | **Employee Termination Agreement (Letter)** |
| ***Purpose & Use*** | Use this form to ensure continued HIPAA compliance when an employee leaves for any reason |

# Roosevelt Dental Center of Skagit County

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# USER'S GUIDE

## *HIPAA Privacy and Security Programs*

### *BUSINESS ASSOCIATE- RELATED FORMS*

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| ***TITLE*** | **Business Associate Agreement** |
| ***Purpose & Use*** | All business associates who are not covered entities under HIPAA, but with whom you share protected patient information MUST sign this agreement. ***Example****: Collection Agencies, Medical Laboratories, etc.* |
| ***TITLE*** | **Exhibit A – Business Associate Permitted uses and Disclosures** |
| ***Purpose & Use*** | Use this form as an addendum to the Business Associate Agreement to identify the purpose, limitations, uses and limitations of PHI being disclosed to the Business Associate. |
| ***TITLE*** | **Exhibit B – Business Associate Verification of Compliance** |
| ***Purpose & Use*** | Use this form to verify that the Business Associate has completed all necessary requirements and is in full compliance with all required HIPAA rules and the Business Associate Agreement to which it is attached |
| ***TITLE*** | **Business Associate Obligation to Comply with HIPAA Rules – (Letter)** |
| ***Purpose & Use*** | Use this form to verify that the Business Associate understands and agrees to abide by the requirements of the HIPAA rules and this Business Associate Agreement. |
| ***TITLE*** | **Cover Letter for Business Associate Agreements** |
| ***Purpose & Use*** | Use this letter to explain to Business Associates why they a re required to sign a BAA. |
| ***TITLE*** | **Business Associate Termination (Letter)** |
| ***Purpose & Use*** | Use this form to ensure that Business Associates continue to abide by HIPAA and protect PHI after your business relationship has ended. |
| ***TITLE*** | **Vendor Visitor Confidentiality Agreement** |
| ***Purpose & Use*** | Use this form to get written agreement to abide by HIPAA from professionals visiting your practice. |

### *BREACH NOTIFICATION FORMS*

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|---|---|
| ***TITLE*** | **Notice to Patient Breach of Protected Health Information (Letter)** |
| ***Purpose & Use*** | Use this letter to notify patient(s) that certain of their PHI has been accessed and/or disclosed without patient authorization or consent. |
| ***TITLE*** | **Notification to Secretary of HHS** of Breach of Unsecured PHI |
| ***Purpose & Use*** | Use this form to notify the Secretary of Health and Human Services of the breach of unsecured Protected Health Information involving 500 or more patients. |

# Roosevelt Dental Center of Skagit County

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## *HIPAA Privacy and Security Programs*

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|---|---|
| ***TITLE*** | **Documentation of Risk Assessment Associated with Breach of PHI** |
| ***Purpose & Use*** | Use this form to conduct and document an investigation of a reported breach of secured protected information and establish the steps necessary to ensure further breaches are avoided. |

***ELECTRONIC SECURITY-RELATED FORMS***

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|---|---|
| ***TITLE*** | **Equipment and Media Inventory** |
| ***Purpose & Use*** | Use this form to document and identify all equipment and electronic media containing EPHI. Complete this form annually and whenever equipment or media is relocated. |
| ***TITLE*** | **EPHI Access Level Determination Record** |
| ***Purpose & Use*** | Use this form to document each staff member's authorized EPHI access level. Enter current information on this form for each employee and whenever employee access levels change. |
| ***TITLE*** | **Security Threat Evaluation** |
| ***Purpose & Use*** | Use this form to document potential threats to EPHI in your practice. Complete this form annually and whenever additional threats are identified. |
| ***TITLE*** | **Security Incident Report** |
| ***Purpose & Use*** | Use this form to document all security incidents, whether accidental or intentional. |
| ***TITLE*** | **Vendor Visitor Confidentiality Agreement** |
| ***Purpose & Use*** | Use this form when visited by a non-business Associate vendor to ensure that if they are restricted from accessing, inspecting, using, or disclosing any confidential information encountered in this facility without prior authorization from the practice's privacy or security officer. |
| ***TITLE*** | **Vendor Technical Compliance Statement** |
| ***Purpose & Use*** | Use this form to confirm that the equipment, programming and software provided to your practice meet the requirements of HIPAA. Maintain a signed copy for each technical vendor. |
| ***TITLE*** | **Service Provider Contact List** |
| ***Purpose & Use*** | Use this form to summarize contact information for all service providers who support your electronic systems and software. Complete this form annually and whenever service provider information changes. |

# Roosevelt Dental Center of Skagit County



## STATEMENT OF PRIVACY PRACTICES OVERVIEW

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

### PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

### COLLECTING PROTECTED HEALTH INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

### DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

### YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

**IF** you'd like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.

# STATEMENT OF PRIVACY PRACTICES

*THIS STATEMENT OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.* ***PLEASE READ CAREFULLY***

Roosevelt Dental Center of Skagit County collects and maintains a record of the health care services we provide you. In keeping with the Health Insurance Portability and Accountability Act (HIPAA), and the State of Washington, we are dedicated to protecting your rights of privacy and the confidential information entrusted to us.

The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We will not disclose your protected health information unless you direct or authorize us to do so or unless it is otherwise allowed or compelled by law. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

You may see your record or get more information about it at "Your Individual Rights about Patient Health Information" section of the Notice. You may request to review and copy your personal record and you may also request that we make corrections to the record.

## OVERVIEW

Our Statement of Privacy Practices is currently in effect and provides information about the use and disclosure of protected health information by Roosevelt Dental Center of Skagit County and our employees. It is applicable in all instances wherein individually identifiable health information is collected from you and services are provided for you. Our Statement:

1. Defines your rights and our obligations when using your health Information,
2. Informs you about laws that provide special protections,
3. Explains how your protected health information is used and how, under certain circumstances, it may be disclosed,
4. Tells you how changes in this statement will be made available to you.

In synopsis form, you have a right to:

1. Request restricted use of your health information. (Please understand that we may not agree to your request),
2. Request that we not disclose to your health plan of services for which you self-pay in full,
3. Request that we communicate with you by alternate methods,
4. Review and receive copies of your personal health record,
5. Request for amendments and/or changes be made to your record,
6. Request an accounting of disclosures of your health information,
7. File complaints related to failure to protect of privacy of your health information,
8. Direct us not to share information with your family members,
9. Request that you not be listed in/on our facility directory.

## PROTECTED HEALTHCARE INFORMATION

It is important that you know not only that we limit requests for your personal information to that needed to provide quality health care, implement payment activities, and conduct normal health practice operations, but understand what "Protected Healthcare Information" is. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, and/or any personal information that is unique to you.

While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

## PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the HIPAA and the state of Washington. This includes when it is used and disclosed to perform treatment, obtain payment, and conduct operational activities. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our Statement of Privacy Practices applies to all personal health information collected or created by Roosevelt Dental Center of Skagit County or received from outside healthcare providers. This information may identify you, relate to your past, present or future physical or mental condition, the care provided, or any reference to payment for your health care.

For example, protected health information includes symptoms, test results, diagnoses, health information from other providers, as well as billing and payment information relating to these services. This information is protected because it is often part of your health or medical record, which we can use as:

1. A method of communication among health professionals who contribute to your care,
2. A legal record describing the care you received,
3. A means by which you can verify that services billed were provided,
4. A tool to educate health professionals,
5. A source of data for medical research,
6. A source of information for public health officials,
7. A source of information for facility planning,
8. A tool to assess and improve the care we provide,
9. A method by which we can provide a better understanding of your record,
10. A method by which we can ensure your record's accuracy,
11. A system to assist you to more clearly understand the circumstances and conditions in and by which others may have access to your personal information.
12. At tool for us to make more informed decisions when authorizing disclosures to others.

## USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

### WITHOUT YOUR AUTHORIZATION

As stated above we may, under allowed circumstances use and disclose protected health information (PHI) without your specific authorization. Examples of such instances are included below:

**Treatment:** We may use and disclose your PHI to provide treatment. For example, we can:

1. Use your information to find out whether certain tests, therapies, and medicines should be ordered,
2. Provide your information to staff members to better understand what your healthcare needs are how to evaluate your response to treatment,
3. Disclose your PHI to another one of your treatment providers in the in order to provide you with the best possible health care.

**Payment:** We may use your health information for payment purposes. Such instances may include:

1. Preparation of claims for payment of services,
2. Billing your insurance directly, including information that identifies you, as well as your diagnosis, the procedures performed, and supplies used so that we can be paid for the treatment provided,
3. Collection activities (if necessary) to obtain payment for services.

**Health Care Operations:** We may use and disclose your health information to support the daily activities related to health care. Examples include:

1. Use and disclosure to monitor and improve our health services.
2. Use by authorized staff to review at portions of your record to perform administrative activities.

**Train Staff and Students:** We may use and disclose your information to teach and train staff how to review patient health information.

**Contact You for Information:** Your PHI may also be used to contact you. In example, we may call you or send you a letter to remind you about your appointment, provide test results, inform you about treatment options, or advise you about other health-related benefits and services.

**Business Associates.** Your PHI may be used by the Roosevelt Dental Center of Skagit County and disclosed to individuals, organizations, or companies that us or to comply with our legal obligations as described in this Notice. An example is disclosure of your PHI to consultants, attorneys or third parties to assist in our business activities. All such entities must sign a Business Associate Agreement to protect the confidentiality of your private information.

### ADDITIONAL USES AND DISCLOSURES

We also use and disclose your information to enhance health care services, protect patient safety, safeguard public health, ensure that our facilities and staff comply with government and accreditation standards, and when otherwise compelled or allowed by law. For example, we provide or disclose information:

1. About FDA-regulated drugs and devices to the U.S. Food and Drug Administration.
2. To government oversight agencies with data for health oversight activities such as auditing or licensure.
3. To public health authorities with information on communicable diseases and vital records.
4. To your employer, findings relating to the evaluation of work-related illnesses or injuries.
5. To workers' compensation agencies and self-insured employers for work-related illness or injuries.
6. To appropriate government agencies when we suspect abuse or neglect.
7. To appropriate agencies or persons when we believe it necessary to avoid a serious threat to health or safety or to prevent serious harm.
8. To organ procurement organizations to coordinate organ donation activities.
9. To law enforcement when required or allowed by law, including the Office of Civil Rights to conduct OCR investigations.
10. For court order or lawful subpoena.
11. To coroners, medical examiners, and funeral directors.
12. To government officials when required for specifically identified functions such as national security.
13. When otherwise required by law, such as to the Secretary of the United States Department of Health and Human Services for purposes of determining compliance with our obligations to protect the privacy of your health information.
14. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

### YOUR RIGHTS TO OBJECT

**Disclosure to Family, Friends, or Others**. You may object to our disclosing your general health condition ("good", "fair", "critical", etc.) to an individual, or individuals, you have identified who have an active interest in your care, payment for your health care, or who may need to notify others about your general condition, location, or death. If you do not so indicate, we will use our best professional judgment to provide relevant protected health information to your family member, friend, or another identified person.

## USE AND DISCLOSURE REQUIRING YOUR AUTHORIZATION

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. You may revoke your written authorization, at any time unless prohibited by law, or disclosure is required for us to obtain payment for services already provided, or we have otherwise relied on the authorization.

## ADDITIONAL PROTECTION OF YOUR PATIENT HEALTH INFORMATION

Special state and federal laws apply to certain classes of patient health information. For example, additional protections may apply to information about sexually transmitted diseases, drug and alcohol abuse treatment records, mental health records, and HIV/AIDS information. When required by law, we will obtain your authorization before releasing this type of information.

## YOUR INDIVIDUAL RIGHTS ABOUT PATIENT HEALTH INFORMATION

You may contact Roosevelt Dental Center of Skagit County to exercise your rights related to the use and disclosure of your protected health information. You may contact us at:

**Roosevelt Dental Center of Skagit County**
**1210 Roosevelt Ave**
**Mount Vernon, Washington 98273**
**Attn: Dr. Rentschler**
**360-424-5650**

Your specific rights are listed include:

1. **The right to request restricted use:** You may request in writing that we not use or disclose your information for treatment, payment, and/or operational activities except when authorized by you, when required by law, or in emergency circumstances. We are not legally required to agree to your request. If you request that we restrict the use of your private information, we will provide you with written notice of our decision about your request.
2. **The right to request non-disclosure to health plans:** You have the right to request in writing that health care items or services for which you self-pay for in full in advance of your visit not be disclosed to your health plan.
3. **The right to receive confidential communications:** You have the right to request that we communicate with you about medical matters in a particular way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the address above. We will grant all reasonable requests. Your request must specify how or where you wish to be contacted.
4. **The right to inspect and receive copies:** In most cases, you have the right to inspect and receive a copy of certain health care information including certain medical and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
5. **The right to request an amendment to your record:** If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that we make a correction or add information. In your request for the amendment, you must give a reason for the amendment. We are not required to agree to the amendment of your record, but a copy of your request will be added to your record.
6. **The right to know about disclosures:** You have the right to receive a list of instances in which we have disclosed your health information. Certain instances will not appear on the list,

such as disclosures for treatment, payment, or health care operations or when you have authorized the use or disclosure. Your first accounting of disclosures in a calendar year is free of charge. Any additional request within the same calendar year requires a processing fee.

7. **The right to make complaints:** If you believe that we have violated your privacy, or you disagree with a decision we made about access to your records, you may file a complaint directly to Dr. Rentschler using the contact information above. Neither Dr. Rentschler, nor any employee of Roosevelt Dental Center of Skagit County will retaliate against anyone for filing a complaint.

You may also contact:

**U.S. Department of Health and Human Services,**
**Office for Civil Rights:**
**2201 Sixth Avenue - Mail Stop RX-11**
**Seattle, WA 98121-1831**
**206-615-2290; 206-615-2296 (TTY)**
**206-615-2297 (fax)**
**Toll free: 1-800-362-1710; 1-800-537-7697 (TTY)**

## BREACH NOTIFICATION

If it is found that your patient information is used or disclosed in a manner that is not consistent with the practices described in this notice, Roosevelt Dental Center of Skagit County will fully investigate the matter to assess if there was a breach in the protection of your PPE. The assessment will be conducted to determine whether the information that was used or disclosed has significant risk of physical, financial, or reputational harm to you. If so, Roosevelt Dental Center of Skagit County will notify you and Health and Human Services in writing.

## PRIVACY NOTICE CHANGES

We are required by law to protect the privacy of your information, to provide this Statement of Privacy Practices and to follow the privacy practices that are described herein. We reserve the right to change the privacy practices described and the right to make the revised or changed Statement effective for protected health information we already have as well as any information we may receive in the future.

We have posted a copy of our current Statement for your review and reference. Additionally, each time you visit our office for treatment or health care services, you may request a copy of our current Statement of Privacy Practices. An electronic version of the notice is posted at our website.

# Roosevelt Dental Center of Skagit County



## ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Roosevelt Dental Center of Skagit County. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Roosevelt Dental Center of Skagit County reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

## ADDITIONAL DISCLOSURE AUTHORIZATION

***In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)***

| | | |
|---|---|---|
| **Spouse only** | ☐ **YES** | ☐ **NO** |
| **OR** | | |
| **Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses)** | ☐ **YES** | ☐ **NO** |
| **Any Member of my extended family: (i.e. Parents, Grandchildren)** | ☐ **YES** | ☐ **NO** |
| **OTHER:** | ☐ **YES** | ☐ **NO** |

**Name of patient (please print):**

**Patient signature (if 18+ years of age):**

**Patient's personal representative: (Please Print):**

**Personal Representative's signature**:

**Representative's Telephone Number:** **Date:**

OFFICE USE ONLY BELOW THIS LINE

### Acknowledgement Not Obtained

| | | | |
|---|---|---|---|
| **Provided Prior to Treatment?** | ☐ **YES** | ☐ **NO** | **Date Statement Provided:** |
| **Reason for not obtaining patient signature:** | ☐ | **Needed more time to review Statement** | |
| | ☐ | **Wanted to consult another person before signing** | |
| | ☐ | **Physically unable to sign** | |
| | ☐ | **No reason offered** | |

# Roosevelt Dental Center of Skagit County



| | | |
|---|---|---|
| | ☐ | **Other:** |

## PATIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

**Patient Name:**

**Patient Information Requested:**

**Patient Signature:**

You have the right to inspect and obtain copies of your medical records or billing record. Under the following circumstances, we can deny your request to inspect and/or obtain copies of your medical or billing records. Should your request be denied, in part or whole, you have the right to have our denial reviewed by a licensed health care professional who did not participate in our original decision. In keeping with the HIPAA rules, you request may be denied for the following reasons:

- When we determine that the information you request is likely to endanger your life or physical safety or the life or safety of another person,
- When we determine that the protected health information you want to inspect makes reference to another person and the access to that information is likely to cause substantial harm to that other person,
- When the request for information is made by your personal representative and we determine that providing access to your representative is likely to cause you substantial harm.

In keeping with the established rules under the HIPAA you do not have the right to inspect:

- Information that has been compiled in reasonable anticipation of a civil, criminal, or administrative action or proceeding.
- Protected health information that is subject to the Clinical Laboratory Improvements Amendments of 1988, i.e. certain laboratory test results.
- Protected health information that is contained in records that have been released to U.S. government agency for a civil or criminal law enforcement activity if the activity has been authorized by law.
- Protected health information that was created during a course of research that includes treatment, provided you agreed to the denial of access when you consented to participate in the research. (This is a temporary suspension and you may review your protected health information when the research is completed);
- Protected health information that was obtained from someone other than this office under a promise of confidentiality and the requested access to this protected health information would likely reveal the source of the information.
- Psychotherapy notes.

OFFICE USE ONLY BELOW THIS LINE

| | | |
|---|---|---|
| **Request for Access to PHI approved ?:** | ☐ **YES** | ☐ **NO** |

# Roosevelt Dental Center of Skagit County



**If request was denied, reason for denial: _____**

## NOTICE OF DECISION REGARDING PATIENT'S REQUEST TO ACCESS PHI

| | |
|---|---|
| **Patient name:** | |
| **Date request for access received:** | |
| **Your request for access to your protected health information has been:** | ☐ **Approved**<br>☐ **Denied** |
| **If your request is approved:** | **Your request to access to Protected Health Information has been approved; the requested information/materials will be available to you as described below. Unless other arrangements have been made, you may pick up your copies during our regular business hours, after the date indicated below. You may be required to pay for researching, copying, and editing of records before material will be released to you.** |
| **Estimated Charges:** | |
| **Availability date** | |
| | |
| **If your request is denied** | **Your request to access Protected Health Information has been denied. You have the right to have this denial reviewed by a licensed healthcare professional who did not participate in our original decision. If you would like your denial reviewed, please indicate by your signature below.** |

| | |
|---|---|
| **Reason for Denial:** | |

***I request that denial of my request to access my Protected Health Information be reviewed by another healthcare professional who was not involved in the original denial decision.***

**Signature of patient**: _____ **Date:** _____

# Roosevelt Dental Center of Skagit County



## NOTICE OF DECISION REGARDING PATIENT'S REQUEST TO AMEND RECORD

| | | | |
|---|---|---|---|
| **Patient's name** | | | |
| **Patient's mailing address** | **City** | **State** | **Zip Code** |
| **Date Patient Notified:** | | | |

**Your request to amend /correct your personal medical records has been addressed and the following determination has been made?**

☐ **Request Approved** ☐ **Request Denied**

**The Request was denied for the following reason(s):**

- ☐ **The information you want amended is accurate and complete.**
- ☐ **Our office did not create the information you want amended.** (We may still consider your request if you can provide us reasonable proof that you cannot locate the person who created this information.)
- ☐ **The information you want amended is not maintained by this office.**
- ☐ **The information you want amended is not part of your medical or financial records.**
- ☐ **The information you want amended is not available due to a pending civil, criminal, or administrative action.**
- ☐ **The information you want amended is no longer exists or cannot be found.**

**Comments by Dr. Rentschler:**

**Date:**

If we have denied your requested amendment, you have the right to submit a written statement disagreeing with the denial and your reason for the disagreement. We have the right to prepare a rebuttal to your written statement of disagreement and provide you with a copy.

If we have denied your requested amendment and you do not want submit a written statement of disagreement, you may still request that we include a copy of this document with any future disclosures of the information identified in your original request. Please make your request in writing, signed and dated.

# Roosevelt Dental Center of Skagit County



## PATIENT REQUEST TO AMEND RECORD

| | | | |
|---|---|---|---|
| **Patient Name:** | | | **Date of Birth:** |
| **Street Address** | **City** | **State** | **Zip Code** |
| **Day time phone number** | | **Evening phone number** | |

You have the right to request amendments to your medical treatment records or billing records. This right does not permit you to alter or change the original record. However, if we accept your requested amendment, we will enter your amendment to the appropriate place in the medical treatment or billing record.

We may deny your request to amend or correct your records under the following circumstances:

- Our office did not create the information you want amended. (We may still consider your request if you can provide us reasonable proof that you cannot locate the person who created this information.)
- The information you want amended is not part of your treatment or billing record.
- The information you want amended is not available due to a pending civil, criminal, or administrative action.
- We believe the information you want amended is accurate and complete.

**Description of entries or current language you wish to be amended: (**If additional space is needed, please include a separate page.)

**Description of requested entries and/or proposed amendment language: (**If additional space is needed, please include a separate page.)

**Reason for amendment or correction: (**If additional space is needed, please include a separate page.)

**Please identify anyone you'd like us to forward the amendment(s) to: (**If additional space is needed, please include a separate page.)

| | |
|---|---|
| **Signature of patient or legally authorized individual:** | **Date:** |
| **Relationship to patient if signed by legally authorized individual:** | |

OFFICE USE ONLY BELOW THIS LINE

| | | | |
|---|---|---|---|
| **Date Request Received** | | **Request Final Decision** | ☐ **Approved** ☐ **Denied** |
| **Request reviewed by:** | | **Reviewer's signature** | |
| **Date of decision** | | **Date Patient notified of decision** | |

# Roosevelt Dental Center of Skagit County



## PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATION

You have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you:

(1) Specify the primary address, telephone number and/or alternative means of contract, and
(2) Specify and/all alternative location(s), address, or telephone number and/or the alternative means of contact; and
(3) Agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that you understand and agree to the above information.

**Dental/Medical Information to be communicated confidentially:**

| |
|---|
| |
| |
| |

**Requested primary delivery location for confidential medical information:**

| Contact | Street Address | City | State |
|---|---|---|---|
| | | | |

**Requested alternative delivery location for confidential medical information:**

| | Contact | Street Address | City | State |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

**Alternative means of contact:**

| | | | | |
|---|---|---|---|---|
| 1. | | | | |

| | |
|---|---|
| **Patient name:** | |
| **Patient Signature** | |

# Roosevelt Dental Center of Skagit County



## PATIENT REQUEST FOR RESTRICTION ON USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

You have the right to request that we restrict our use and disclosure of your protected health information. This includes the right, as allowed by the HIPAA, to request that your insurance plan not be notified of services provided for which I pay by cash, out-of-pocket, at the time the services are provided.

Except as otherwise required by law, we are not required to agree with your requested restrictions. However, if we do agree to the requested restrictions, we will abide by them unless a medical emergency requires otherwise.

We reserve the right to terminate your requested restriction if:

- You agree to termination of the restriction, either in writing or verbally; or
- You request the termination yourself.

| | | | |
|---|---|---|---|
| **Patient Name** | | | |
| **Street Address** | **City** | **State** | **Zip Code** |
| | | | |
| **Daytime Telephone** | | **Evening Telephone** | |
| **Today's date:** | | | |
| **Description of PHI to be restricted:** | | | |
| | | | |
| | | | |
| | | | |
| **Nature of restriction:** | | | |
| | | | |
| | | | |
| | | | |
| **Patient Signature** | | | |
| **Date:** | | | |

OFFICE USE ONLY BELOW THIS LINE

| | |
|---|---|
| **Restriction Decision:** | ☐ **Request Approved** ☐ **Request Denied** |

# Roosevelt Dental Center of Skagit County



## AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION REQUESTED BY DR. RENTSCHLER

I, _____, hereby authorize Dr. Rentschler to:
(Name of patient)

**(PLEASE CHECK ALL THAT APPLY)**

- ☐ Use the following protected health information, and or
- ☐ Disclose the following protected health information to:

_____
NAME OF ENTITY TO RECEIVE INFORMATION

### DESCRIPTION OF INFORMATION TO BE RELEASED

In the space below, describe the information to be used or disclosed, including descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

### REASON FOR RELEASE OF INFORMATION▼

In the space below, describe the specific purposes

### DURATION OF AUTHORIZATION▼

In the space below, input the duration of the authorization, or the specific event requiring disclosure.

**This authorization shall be in force and effect until:**

- ❑ The date of _____ or,
  (Enter date)
- ❑ A specific event that relates to the patient or the purpose of the use or disclosure, as described below, at which time this authorization to use or disclose this protected health information expires.

Description of terminating event:

_____

_____

I understand that I have the right to revoke this authorization at any time by sending written notification to Dr. Rentschler. I understand that any revocation is not effective to the extent that Dr. Rentschler has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal and/or state law.
- Refuse to sign this authorization.

I understand that Dr. Rentschler, or staff members of Roosevelt Dental Center of Skagit County will not condition my treatment on whether I provide authorization for the requested use or disclosure, except under the following circumstance:

- When the provision of care by Dr. Rentschler is solely for the purpose of creating protected health information for disclosure to a third party, when such disclosure is contingent upon my **authorization**.

| | |
|---|---|
| **Name of Patient or personal representative** | |
| **Signature of patient or personal representative** | |
| **Description of personal representative's authority to represent patient** | |
| **Date:** | |

# Roosevelt Dental Center of Skagit County



## RECORD OF PATIENT COMPLAINT

**You have the right to register a complaint concerning our HIPAA policies and procedures or our compliance with these policies and procedures under the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended.**

**We encourage you to submit your complaint to our office first. However, you do have the right to complain directly to the Secretary of the Department of Health and Human Services.We will make every attempt to address your complaint immediately. If you do submit a complaint, we will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against you, and will not compromise your treatment.**

| **Patient Name:** | |
|---|---|

### Nature and Description of Complaint

***In the space below, please describe your concern and complaint. Please be as specific and complete as possible*.** (If additional space is needed, please include a separate page**).**

| |
|---|
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| |
| |

| **Patient signature:** | | **Date** | |
|---|---|---|---|
| **Date received:** | | **Received by** | |

# Roosevelt Dental Center of Skagit County



## PATIENT HIPAA COMPLAINT LOG

| | | | |
|---|---|---|---|
| **Patient Name** | | | |
| **Date complaint received** | | **Received by:** | |
| | | | |
| **Date of resolution:** | | | |
| | | | |
| **Patient Name** | | | |
| **Date complaint received** | | **Received by:** | |
| | | | |
| **Date of resolution:** | | | |
| | | | |
| **Patient Name** | | | |
| **Date complaint received** | | **Received by:** | |
| | | | |
| **Date of resolution:** | | | |
| | | | |
| **Date complaint received** | | **Received by:** | |
| | | | |
| **Date of resolution:** | | | |

# Roosevelt Dental Center of Skagit County



## EMPLOYEE HIPAA CONFIDENTIALITY AGREEMENT

I understand that while performing my duties, I might have access to information that is classified as confidential, sensitive, or Protected Health Information (PHI). Confidential information is information that identifies an individual. Sensitive information may be financial or operational information that requires the maintenance of its integrity and assurance of its accuracy and completeness. Protected Health Information (PHI) means individually identifiable health information that is transmitted or maintained in any form or medium. Confidential, sensitive, and protected health information is not open or available to the public. Special precautions are necessary to protect this type of information from unauthorized access, use, modification, disclosure, and/or destruction.

| **I agree to protect the following types of information:** |
|---|
| ☐ **All patient protected health information.** |
| ☐ **Information about how the office computer systems are accessed and operated.** |
| ☐ **Any other proprietary information about the office such as operational information or instructional manuals.** |
| **I agree to protect confidential and sensitive PHI by:** |
| ☐ **Accessing, using, or modifying confidential and/or sensitive and/or PHI only for the purpose of performing my official duties.** |
| ☐ **Never sharing passwords or logon codes with anyone or storing passwords or codes in a location accessible to unauthorized persons.** |
| ☐ **Never attempting to learn or use another employee's password or logon code.** |
| ☐ **Never accessing or using confidential, sensitive, and/or PHI out of curiosity, or for personal interest or advantage.** |
| ☐ **Never showing, discussing, or disclosing confidential, sensitive, and/or PHI to or with anyone who does not have the legal authority or the "need to know".** |
| ☐ **Never leaving a secure computer application unattended while signed on.** |
| ☐ **Storing confidential and/or sensitive information in a place physically secure from access by unauthorized persons.** |
| ☐ **Never removing confidential, sensitive, and/or PHI from the work area without authorization** |
| ☐ **Disposing of confidential, sensitive and/or PHI by utilizing an approved method of destruction, which may include shredding, burning, or certified or witnessed destruction. Never disposing of such information in the wastebaskets or recycle bins.** |
| ☐ **Immediately notifying the proper person if I have reason to believe my password or logon code has been compromised** |

| **<u>Penalties:</u> I understand the penalties for unauthorized access, use, modification, disclosure, or destruction of confidential, sensitive, and or PHI may include disciplinary action, up to and including termination of my employment, and/or criminal or civil action.** | |
|---|---|
| | |
| ***I certify that I have read and understand the Confidentiality Statement printed above.*** | |
| **Employee Signature** | |
| **Date:** | |

# Roosevelt Dental Center of Skagit County



## EMPLOYEE HIPAA TRAINING RECORD

| | Employee Name (Please Print) | Employee Signature | Training Date |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |
| 13 | | | |
| 14 | | | |
| 15 | | | |
| 16 | | | |
| 17 | | | |
| 18 | | | |
| 19 | | | |
| 20 | | | |
| 21 | | | |

# EMPLOYEE NOTICE OF DISCLOSURE VIOLATION AND REPRIMAND

SAMPLE LETTER

_____ [Date]

**TO**: _____ [Employee]

**Subject**: Violation of HIPAA Rules

**Dear** _____ [Employee]:

As an employee of Roosevelt Dental Center of Skagit County your duties involve access to patient information that is protected under the Health Insurance Portability and Accountability Act of 1996. As a condition of your employment, you received training in HIPAA Privacy and Security Rules and agreed, in writing, that you will protect such information. Your agreement also states that you understand and agree that you are subject to disciplinary action for violations of HIPAA.

You were recently involved in a breach of HIPAA and the privacy practices of this office.

**Describe violation/incident here:**

| |
|---|
| |

After reviewing the incident, it has been determined that the following disciplinary action is appropriate for this violation.

**Describe disciplinary action here**

(Example: Verbal reprimand; Days off without pay; termination, etc.)

| |
|---|
| |

A copy of this letter will be placed in your personnel file. Please understand that the penalties for future violations, unauthorized access, use, modification, disclosure, or destruction may include further disciplinary action, up to and including termination of your employment and/or criminal or civil action.

Sincerely,

_____

Dr. Rentschler

# Roosevelt Dental Center of Skagit County



## EMPLOYEE TERMINATION AGREEMENT

SAMPLE LETTER

_____ [Date]

TO: _____ [Employee]

Subject: Employee Termination Checklist

Dear _____ [Employee]:

While employed at Roosevelt Dental Center of Skagit County your duties involved access to patient information that is protected under the Health Insurance Portability and Accountability Act of 1996. As a condition of your employment, you received training in HIPAA and agreed, in writing, that you would protect such information. Your agreement also states that you understand and agree to abide by the requirements of HIPAA. Your obligation to abide by HIPAA applies to any and all information to which you may have been exposed while in the employ of Roosevelt Dental Center of Skagit County and remains in force after you have leave the employ of this office.

Please remember any violations, unauthorized access, use, modification, disclosure, or destruction of any protected information you may have accessed as an employee of this office remain confidential with unauthorized disclosures subject to civil or criminal prosecution.

| HIPAA Termination Checklist | Sign when completed |
|---|---|
| **Collect keys, access cards, etc.** | |
| **Delete/change passwords or other access controls (including remote computer access and mobile devices)** | |
| **Company Equipment** | |
| **Credit cards /access cards** | |
| **Other:** | |
| **Other** | |

I hereby attest and affirm that I will continue to abide by the requirements of the Health Insurance Portability and Accountability Act of 1996 and that I have returned all property belonging to Roosevelt Dental Center of Skagit County.

_____ _____

Signature of Employee Signature of Witness

Date: _____ Date: _____

## BUSINESS ASSOCIATE AGREEMENT

| | | | |
|---|---|---|---|
| **Covered Entity** | **Roosevelt Dental Center of Skagit County** | | |
| **Covered Entity doing business as:** (dental practice, medical practice, etc.) | | | |
| **Covered Entity organized Under the laws of the state of:** | **Washington** | | |
| **Legal name of Business Associate and (if) DBA** | | | |
| **Business Associate Address** | **Address** | **State** | **Zip Code** |
| **Business Associate Telephone** | **Primary Number** | **FAX Number** | |
| **Business Associate doing Business as:** (IT consultant, collection agency, etc.) | | | |
| **Business Associate organized Under the laws of the state of:** | | | |

***WITNESSETH:***

COMPLETE THIS SECTION IF PARTIES HAVE A PRIOR AGREEMENT

WHEREAS, the parties have a prior agreement dated: _____ (the "Prior Agreement") pursuant to which the Business Associate has used, received or disclosed information which would meet the definition of Protected Health Information in this Agreement. The parties wish to supplement our prior Business Agreement with this Agreement, which will establish the terms and conditions under which the Protected Health Information provided to or created by the Business Associate from or on behalf of Roosevelt Dental Center of Skagit County will be handled by and between the parties and with any third parties during the term of this Agreement. This Agreement shall govern in the event of any conflict between this Agreement and the prior Agreement.]

WHEREAS, Roosevelt Dental Center of Skagit County will make available to Business Associate certain information, in conjunction with goods or services that are being provided by Business Associate to Roosevelt Dental Center of Skagit County that is confidential and must be afforded confidential treatment and protection in accordance with the Standards for Privacy of Individually Identifiable Health

Information (the "Privacy Rule") under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

WHEREAS, Business Associate will have access to and/or receive from Roosevelt Dental Center of Skagit County certain information that can be used or disclosed only in accordance with this Contract and the Privacy Regulations.

NOW, THEREFORE, Roosevelt Dental Center of Skagit County and Business Associate for good and valuable consideration as set forth in this Agreement, and intending to be bound, agree as follows:

## 1. DEFINITIONS

*CATCH-ALL DEFINITION:*

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

*SPECIFIC DEFINITIONS:*

**(i) Business Associate.** Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the person, company, and/or entity identified above as Business Associate. A person, company, or entity is considered a Business Associate if it is:

(i) a person, company, or entity that creates, receives, maintains, or transmits protected health information on behalf of a covered entity,
(ii) a person, company, or entity that performs functions or activities on behalf of, or certain services for, a covered entity that involve the use or disclosure of protected health information.
(iii) a Health Information Service Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires routine access to such protected health information,
(iv) a person who offers a personal health record to one or more individuals on behalf of a covered entity,
(v) a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

**(ii)** ***Breach.*** The unauthorized acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information.

**(iii)** ***Breach Discovery*****.** The first day the breach is known to the covered entity, or by exercising reasonable diligence, would have been known to the covered entity.

**(iv)Covered Entity.** "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Roosevelt Dental Center of Skagit County.

**(v) HIPAA Rules**. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

**(vi) *Facility*.** "Facility" shall mean Roosevelt Dental Center of Skagit County.

**(vii) *Individual*.** "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

**(viii) *Protected Health Information*.** "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

**(ix) *Required by Law*.** "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

**(x) *Secretary*.** "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

## 2. GENERAL LIMIT ON USE AND DISCLOSURE ESTABLISHED BY TERMS OF CONTRACT.

Business Associate hereby agrees that it shall be prohibited from using or disclosing the Protected Health Information provided or made available by Roosevelt Dental Center of Skagit County for any purpose other than as expressly permitted or required by this Contract.

## 3. GENERAL USE AND DISCLOSURE.

Except as otherwise limited in the Contract, Business Associate shall be permitted to use and/or disclose Protected Health Information on behalf of, or to provide services to, Roosevelt Dental Center of Skagit County for the purposes described in Exhibit A (individually and collectively the "Services"), if such use or disclosure of Protected Health Information would not violate the Privacy Rule if done by Roosevelt Dental Center of Skagit County.

## 4. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE:

**(a) No further Use or Disclosure:**

Business Associate agrees to not use or further disclose Protected Health Information provided or made available by Roosevelt Dental Center of Skagit County other than as permitted or required by the Contract or as required by Law.

**(b) Appropriate Safeguards:**

Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information, other than as provided for by this Contract. Appropriate safeguards include, as a minimum:

(i) Implementation of administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that they create, receive, maintain, or transmit on behalf of the covered entity as required by the Security Rule;

(ii) Ensure, through a binding Business Associate Agreement, that any agent, including a subcontractor, to whom primary Business Associate provides such information agrees to implement the same reasonable and appropriate safeguards to protect it.

(iii) Implement administrative safeguards, actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect protected health information and to manage the conduct of the business associate's workforce in relation to the protection of that information.

(iv) Implement physical safeguards, including physical measures, policies, and procedures to protect a covered entity's or business associate's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

(v) Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of all protected health information held by the covered entity or business associate.

(vi) Provide reasonable assurances in written form that the Business Associate will comply with the requirement of the HIPAA rules and undertake all necessary actions and implement all necessary protocols to comply with those rules

**(c) Reports of Improper Use or Disclosure – Breach:**

Business Associate hereby agrees that it shall promptly report to Roosevelt Dental Center of Skagit County any use or disclosure of Protected Health Information not provided for or allowed by this Contract. Business associate will notify Roosevelt Dental Center of Skagit County immediately upon the discovery of any breach of Protected Health Information provided by Roosevelt Dental Center of Skagit County, and identify the individual(s) whose unsecured PHI has been, or is reasonably believed to have been breached. Such notification shall be made without unreasonable delay, but in no case later than 60 calendar days after discovery of the breach unless law enforcement officials have determined that a notification would impede a criminal investigation or cause damage to national security.

**(d) Mitigation Procedures:**

Business Associate agrees to mitigate, to the maximum extent practicable, any harmful effect that is known to the Business Associate from the use or disclosure of Protected Health Information by the Business Associate in violation of the requirements of this Contract.

**(e) Subcontractors and Agents:**

Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created, or received by Business Associate on behalf of Roosevelt Dental Center of Skagit County, agrees to the same terms, conditions and restrictions that apply through this Contract to Business Associate with respect to such information.

**(f) Right of Access to Information:**

Business Associate hereby agrees to provide access, at the request of Roosevelt Dental Center of Skagit County and in the time and manner as negotiated by the Facility and Business Associate**,** to Protected Health Information in a Designated Record Set (as that term is defined in 45 CFR 164.501 of the Privacy Rule, to Roosevelt Dental Center of Skagit County or, as directed by Roosevelt Dental Center of Skagit County**,** to an individual, in order to meet the requirements under the Privacy Rule.

**(g) Amendment and Incorporation of Amendments:**
Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Roosevelt Dental Center of Skagit County directs or agrees to pursuant to the Privacy Rule at the request of Roosevelt Dental Center of Skagit County or an individual, and in the time or manner designated as negotiated by Roosevelt Dental Center of Skagit County and Business Associate.

**(h) Access to Books and Records:**
Business Associate hereby agrees to make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use or disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of Roosevelt Dental Center of Skagit County, available to the Facility, or at the request of Roosevelt Dental Center of Skagit County to the Secretary, in a time and manner as negotiated by Roosevelt Dental Center of Skagit County and Business Associate, or designated by the Secretary, for purposes of the Secretary determining the Facility's compliance with the Privacy Rule.

**(i) Provide Accounting:**

Business Associate agrees to:

**(a)** Document such disclosures of Protected Health Information and information related to such disclosures as would be required for Roosevelt Dental Center of Skagit County to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with the Privacy Rule.

**(b)** Provide to Roosevelt Dental Center of Skagit County or an Individual, in a time and manner as negotiated by Roosevelt Dental Center of Skagit County and Business Associate, Information collected in accordance with this section of this Contract, to permit Roosevelt Dental Center of Skagit County to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with the Privacy Rule.

**(j) Survival:** The Provisions of this Section shall survive the termination of this Agreement.

## 5. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

**(a)** Business associate may only use or disclose protected health information as necessary to perform the services set forth in a "Uses and Disclosure Agreement attached to this contract. In addition to other permissible purposes, the parties should specify whether the business associate is authorized to use protected health information to de-identify the information in accordance with 45 CFR 164.514(a)-(c) only with the written agreement, in a manner and at the written direction of Roosevelt Dental Center of Skagit County.

**(b)** Business associate may use or disclose protected health information as required by law.

**(c)** Business associate agrees to make uses and disclosures and requests for protected health information consistent with Roosevelt Dental Center of Skagit County's minimum necessary policies and procedures.

**(d)** Business associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity except for the specific uses and disclosures set forth below.

**(e)** By prior specific written agreement between Roosevelt Dental Center of Skagit County and the Business associate, the Business Associate may use protected health information for the proper management and administration of the business associate or to carry out the legal responsibilities of the business associate.

## 6. OBLIGATIONS OF ROOSEVELT DENTAL CENTER OF SKAGIT COUNTY

**(a) Statement of Privacy Practices:**

Roosevelt Dental Center of Skagit County agrees to notify Business Associate of any limitations in its Statement of Privacy Practices to the extent that such limitations may affect Business Associate's use or disclosure of Protected Health Information.

**(b) Revocation of Authorization to Use/Disclose PHI:**

Roosevelt Dental Center of Skagit County agrees to notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted uses and disclosures.

**(c) Restrictions to Use/Disclose PHI:**

Roosevelt Dental Center of Skagit County agrees to notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Facility has agreed to in accordance with the Privacy Rule to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

**(d) Permissible Requests:**

Roosevelt Dental Center of Skagit County agrees not to request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule.

## 7. TERM AND TERMINATION:

**(a) Term:**

The Term of this Contract shall commence on _____ and shall terminate:

(i) with respect to the services being provided by Business Associate and the compensation provisions, as of _____ and,

(ii) with respect to the obligations of the Business Associate concerning PHI, when all of the Protected Health Information provided by Roosevelt Dental Center of Skagit County to Business Associate, or created or received by Business Associate on behalf of Roosevelt Dental Center of Skagit County, is destroyed or returned to Facility, or if it is infeasible to return or destroy all Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this section.

**(b) Termination for Cause:**

Upon Facility's knowledge of a material breach by Business Associate, Roosevelt Dental Center of Skagit County shall either: (i) provide an opportunity for Business Associate to cure the breach or (ii) immediately terminate this Agreement without further notice if Business Associate does not cure the breach or end the violation within the time specified by Roosevelt Dental Center of Skagit County or (iii) if neither termination or cure are feasible, Roosevelt Dental Center of Skagit County will report the violation to the Secretary.

**(c) Judicial or Administrative Proceedings; Exclusion:**

Either party may terminate this Agreement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined; or (iii) the other party, or any of its officers, share-holders or management employees has been excluded from the Medicare program.

**(d) Termination without Cause:**

Either party has the right to terminate this Agreement without cause upon giving [180] days written notice.

**(e) Effect of Termination:**

(i) Except as provided in paragraph ii) below, upon termination of this Contract, for any reason, Business Associate hereby agrees to return or destroy all Protected Health Information received from Roosevelt Dental Center of Skagit County, or created or received by Business Associate on behalf of Roosevelt Dental Center of Skagit County**.** This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate**.** Business Associate agrees not to retain any copies of Protected Health Information after termination of this Contract.

(ii) In the event that Business Associate determines that return or destruction of Protected Health Information is not feasible, Business Associate shall provide to Roosevelt Dental Center of Skagit County notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties

that return or destruction of Protected Health Information is not feasible, Business Associate agrees to extend the protections of this Contract to such Protected Health Information and limit any further use or disclosure to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains the information.

8. MISCELLANEOUS

**(a) Audits, Inspection and Enforcement:**

Roosevelt Dental Center of Skagit County has the right, with notice and at its expense, to inspect the facilities, systems, books, and records of Business Associate to monitor compliance with this Addendum. Business Associate shall promptly remedy any violation of any term of this Addendum. Facility's exercise or non-exercise of this right to audit does not relieve Business Associate of its responsibility to comply with this Addendum.

**(b) Disclaimer:**

Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

**(c) Certification:**

Roosevelt Dental Center of Skagit County or its authorized agents or contractors, may, at its expense, examine Business Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to Facility the extent to which Business Associate's security safeguards comply with HIPAA, the Privacy Rule or this Addendum.

**(d) *Amendment*:**

(i). Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to electronic data security and privacy are evolving rapidly and that amendment of this Agreement may be required. The parties agree to take such action as is necessary to implement the standards and requirements of HIPAA, the Privacy Rule and other applicable laws relating to the security or confidentiality of PHI, including adopting any necessary or desirable amendments to this Agreement. The parties understand and agree that Roosevelt Dental Center of Skagit County must receive satisfactory written assurance from Business Associate that Business Associate will adequately safeguard all PHI that it receives or creates pursuant to this Agreement. Either party may terminate this Agreement upon [*30*] days written notice in the event the parties are unable to amend this Agreement in a manner that Facility reasonably believes is necessary under HIPAA.

(ii) Amendment of Exhibit A. Exhibit A may be modified or amended by mutual agreement of the parties at any time without amendment of this Agreement.

**(e) Assistance in Litigation or Administrative Proceedings:**

Business Associate shall make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to Roosevelt Dental Center of Skagit County, at no cost to Roosevelt Dental Center of Skagit County, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Roosevelt Dental Center of Skagit County, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Associate or its subcontractor, employee or agent is a named adverse party.

**(f) No Third Party Beneficiaries:**

Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Facility, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

**(g) Effect on Agreement:**

Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Agreement shall remain in force and effect.

**(h) Interpretation:**

This Addendum and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, HIPAA Regulations, and applicable state laws.

**(i) Indemnity:**

Each party will indemnify, hold harmless and defend the other party to this Agreement from and against any and all claims, losses, liabilities, costs and other expenses incurred as a result of, or arising directly or indirectly out of or in connection with: (i) any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of the party under this Agreement; and (ii) any claims, demands, awards, judgments, actions and proceedings made by any person or organization arising out of or in any way connected with the party's performance under this Agreement.

**(j) Ambiguity:**

The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations.

**(k) Rights and Property:**

All title to the physical records, charts, and other Protected Health Information shall remain the sole property of Facility.

**(l) No Waiver:**

Failure of either party to exercise a right pursuant to this Agreement for any length of time shall not constitute a waiver of said right.

**(m) Modification:**
Modification of the terms of this Agreement shall not be effective or binding upon the parties unless and until such modification is committed to writing and executed by the parties hereto.

**(n) No Assignability:**
This is a contract for personal services, and it is the intent of the Facility to have the services performed by the Business Associate. No right or responsibility of either party shall be assigned except upon the prior written consent of the other party hereto.

**(o) Binding Effect:**
This Agreement shall be binding upon the parties hereto, and their respective legal representatives, trustees, receivers, successors and permitted assigns.

**(p) Severability:**
Should any provision of this Agreement be found unenforceable, it shall be deemed severable and the balance of the Agreement shall continue in full force and effect as if the unenforceable provision had never been made a part hereof.

**(q) Governing Law:**
This Agreement and the rights and obligations of the parties hereunder shall in all respects be governed by, and construed in accordance with, the laws of the State of Washington, including all matters of construction, validity and performance.

**(r) Notices**:
All notices and communications required or permitted to be given hereunder shall be sent by certified mail, addressed to the other party at its respective address as shown on the signature page, or at such other address as such party shall from time to time designate in writing to the other party, and shall be effective from the date of mailing.

**(s) Captions:**
The captions appearing at the beginning of any paragraph or subparagraph hereof are for the convenience of reference only and shall not define or limit any of the terms or conditions hereof and shall have no independent significance.

**(t) Construction:**
The parties acknowledge that they have had the opportunity to be represented by counsel in the negotiation and execution of this Agreement and therefore, it is expressly agreed and in the case of any vagueness or ambiguity with regard to any provision of this Agreement, there shall be no presumption of construction against the drafter of such provision but instead, this Agreement shall be interpreted in accordance with a fair construction of the law.

**(u) Entire Agreement:**
This Agreement, including such portions as are incorporated by reference herein, constitutes the entire agreement by, between and among the parties, and such parties acknowledge by their signatures hereto that they do not rely upon any representations or undertakings by any person or party, past or future, not expressly set forth in writing herein.

**(v) Representation and Warranty.**

The parties warrant that

(i) The execution of this Agreement has been duly authorized by their respective Board of Directors and that the representative executing this Agreement is authorized to do so.
(ii) Neither the party, nor any of its officers, principal owners or managing employees are or have been excluded from participation in the Medicare program, the Medicaid program of any State, or any other state or federal health care program.
(iii) The Business Associate is not currently under investigation by any regulatory body or the state or federal government in connection with any matter concerning Medicare, Medicaid or any other state or federal health care program.

**(w) Reasonableness Standard:**
Whenever any party is required by this Agreement to act or to refrain from acting, such action or restraint shall be interpreted by a standard of commercial reasonableness, to require only those actions or restraints as a reasonable person in the same position would expect.

***IN WITNESS WHEREOF:***

Business Associate and Roosevelt Dental Center of Skagit County have caused this Contract to be signed and delivered by their duly authorized representatives, as of the date set forth above.

| ***BUSINESS ASSOCIATE*** | ***ROOSEVELT DENTAL CENTER OF SKAGIT COUNTY*** |
|---|---|
| By: | By: |
| Print Name: | Print Name: |
| Title: | Title: |

EXHIBIT A

## PERMITTED USES AND DISCLOSURES

This Exhibit sets forth the permitted uses and disclosures of Protected Health Information by Business Associate pursuant to Section 2 of the Addendum to the Agreement by and between Roosevelt Dental Center of Skagit County and Business Associate, dated _____, and is effective as of _____ (the "Exhibit Effective Date"). This Exhibit may be amended from time to time as provided in Section 8(d)(ii) above.

**Purpose(s) of Disclosure**. The purpose(s) for which Roosevelt Dental Center of Skagit County shall disclose Information to Associate are as follows:

**Information to be disclosed.** Roosevelt Dental Center of Skagit County shall disclose the following Information to Business Associate in accordance with the terms of the Agreement:

**Permitted Uses and Disclosures of Information.** Business Associate shall be limited to the following uses and/or disclosures of Facility's PHI

**Subcontractor(s).** If Business Associate intends to utilize any subcontractors in performing Business Associate's obligations under the Agreement, such subcontractors shall be identified as follows:

EXHIBIT B

## BUSINESS ASSOCIATE VERIFICATION OF COMPLIANCE

| | |
|---|---|
| **Covered Entity** | **Roosevelt Dental Center of Skagit County** |
| **Legal name of Business Associate and (if) DBA** | |

This document is presented as verification that the Business Associate identified hereon has completed all necessary requirements and is in full compliance with all required HIPAA rules and the Business Associate Agreement to which it is attached. Specifically, the Business Associate identified above testifies that it has established the appropriate administrative, physical, and electronic safeguards to protect the private and personal, patient protected information of Roosevelt Dental Center of Skagit County t which it has access. Additionally, Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information, as provided for by this Contract. Appropriate safeguards include, but are not limited to:

(i) Implementation of administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that they create, receive, maintain, or transmit on behalf of the covered entity as required by the HIPAA Privacy and Security Rules.

(ii) Ensure, through a binding Business Associate Agreement, that any agent, including a subcontractor, to whom primary Business Associate provides such information agrees to implement the same reasonable and appropriate safeguards to protect it.

(iii) Prepare and implement administrative safeguards, actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect protected health information and to manage the conduct of the business associate's workforce in relation to the protection of that information.

(iv) Implement physical safeguards, including physical measures, policies, and procedures to protect a covered entity's or business associate's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

(v) Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of all protected health information held by the business associate.

(vi) Provide and document appropriate HIPAA training for all employees and representatives of the Business Associate relating to the HIPAA rules and requirements including the individual responsibilities relating to HIPAA rules as employees of the Business Associate.

BUSINESS ASSOCIATE

By: _____ Representative's Title: _____
(Auhorized Signature)

Print Name: _____ Date: _____

# COVER LETTER TO BUSINESS ASSOCIATES

(ATTACHED TO BUSINESS ASSOCIATE AGREEMENT)

SAMPLE LETTER

**To:** _____
(Business Associate)

Dear: _____

Enclosed, please find a Business Associate Agreement we have prepared, as required by the Department of Health and Human Services, under the Health Insurance Portability and Accountability Act (HIPAA). This Agreement establishes and outlines HIPAA's requirements governing the working relationship we, as Covered Entities, have with your firm involving patient information to which your employees have access in the performance of your contracted activities. It has been revised to respond to the amended provisions of the Act by the recent adoption of HIPAA's Omnibus Rule. (Include this last line only if you are updating an existing BAA.)

By definition, a Business Associate is defined as a person, entity, or organization, other than a member of a Covered Entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a Covered entity that involve the use or disclosure of individually identifiable health information. The Business Associate Agreement ensures that the Business Associate will safeguard any and all patient protected health information to which it has access or possession.

Because Business Associates are not otherwise bound by the rules established within the HIPAA, Business Associates must provide "satisfactory assurances", as that term is defined under HIPAA, by way of a written and signed Business Associate Agreement; a written contract that the patient information provided to them will be protected to the letter of the HIPAA rules and requirements.

If you have any questions concerning Business Associate requirements, you can find a complete copy of the Omnibus Rule outlining the conditions relating to the Business Associate on line at http://www.hhs.gov/ocr/hipaa.

Please review and sign the attached Agreement at your earliest opportunity.

Sincerely,

_____

# BUSINESS ASSOCIATE OBLIGATION TO COMPLY WITH HIPAA

SAMPLE LETTER

[Date]

To: _____
[Business Associate]

Subject: HIPAA Obligation

Dear _____
[Business Associate]:

As a Business Associate of Roosevelt Dental Center of Skagit County, our business relationship involves our disclosure of our patient(s) personal Protected Health Information (PHI). Because the PHI is protected under the Health Insurance Portability and Accountability Act of 1996, you entered into a contractual Business Associate Agreement with Roosevelt Dental Center of Skagit County. The agreement states that you understand and agree to abide by the requirements of HIPAA and the HIPAA rules. Your obligation to abide by HIPAA regulations and procedures applies to any and all information to which you might be or have been exposed during the period of our business relationship. The requirement to adhere to HIPAA mandates, and the confidentiality therein established, is life-long and remains in force after the termination of that business relationship.

Please remember and be advised that you remain subject to civil or criminal prosecution for any future violations, unauthorized access, use, modification, disclosure, or destruction of any protected information you may have accessed during the period of our business relationship.

Sincerely,

_____

## BUSINESS ASSOCIATE TERMINATION

_____
[Date]

_____
[Business Associate]

Subject: Termination of Business Association

Dear _____
[Business Associate]:

As a business associate of Roosevelt Dental Center of Skagit County, our business relationship has involved disclosure of information that is protected under the Health Insurance Portability and Accountability Act of 1996. As a condition of our business relationship, you entered into a *BUSINESS ASSOCIATE AGREEMENT* with Roosevelt Dental Center of Skagit County. The agreement stated that you understand and agree to abide by the requirements of HIPAA. Your obligation to abide by HIPAA applies to any and all protected healthcare information you may have been exposed to during the period of our business relationship remains in force after the termination of that business relationship.

Please be advised that you remain subject to civil or criminal prosecution for any future violations, unauthorized access, use, modification, disclosure, or destruction of any protected information you may have accessed during the period of our business relationship.

Sincerely,

_____
Dr. Rentschler
Roosevelt Dental Center of Skagit County

# NOTIFICATION TO PATIENT - BREACH OF PROTECTED HEALTH INFORMATION

SAMPLE LETTER

[Date]

TO: _____
[Patient]

Subject: Notification of Breach of Protected Health Information

Dear _____ [Patient]:

I am writing to advise you that we have recently discovered that certain personal health information we maintain as a part of your private medical records has been accessed without my knowledge or authorization. Under the rules established by the Health Insurance Portability and Accountability Act (HIPAA) it has been determined that a "breach" in the protection of your Protected Health Information has occurred.

We are currently in the process of determining the scope of the breach and to what extent, if any, protected information has been inappropriately disclosed or used. In the interim, we suggest, as a precaution, a couple of things you might do to reduce the chance of being victimized.

1. Check your credit report immediately and at least once a year. Everyone is entitled to a free report annually. Make sure it includes all three consumer reporting companies, Equifax, Experian, and TransUnion. If you find suspicious activity – especially unfamiliar accounts – call the police, the creditor, and the credit reporting agency.

2. Credit Report Fraud Alerts can be placed on your account by calling Equifax – 800-525-6285, Experian – 888-397-3742, and TransUnion – 800-680-7289. You can place a 90-day or 7-year alert that can prevent a thief from opening accounts in your name. Be aware that fraud alerts may cause delays if you're trying to obtain credit.

Every effort is being made to ensure the protected information is returned. Additionally, we are reviewing our systems, procedures, and protocols to determine the method by which the breach occurred and will implement any changes necessary to ensure that further breaches are avoided.

We apologize for any inconvenience this incident might have caused you. A copy of the report to Health and Human Services is enclosed for your information and records. If you have any questions, please call me personally at 360-424-5650.

Sincerely,

_____
Dr. Rentschler

# NOTIFICATION TO THE SECRETARY OF HHS - BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

We are notifying you in keeping with our Statement of Privacy Practices and as required by the Department of Health and Human Services, Section 164.400 of the Heath Insurance Portability and Accountability Act, "Breach Notification for Unsecured Protected Health Information". This Breach Report provides the information concerning the discovered breach.

| | | |
|---|---|---|
| **Breach Report Type** | ☐ Initial Breach Report | ☐ Addendum to Previous Report |
| **Breach Affecting** | ☐ 500 or More Individuals | ☐ Less than 500 Individuals |

## Section 1 – Covered Entity

| | |
|---|---|
| **Name of Covered Entity** | **Roosevelt Dental Center of Skagit County** |
| **Address** | **Mount Vernon, Washington 98273** |
| **Contact Name** | **Hailey Johnson** |
| **Contact Telephone** | **360-424-5650** |
| **Contact E-mail** | |
| **Type of Covered Entity** | |

## Section 2 – Business Associate

Complete this section only if the breach occurred
at or by a Business Associate

| | |
|---|---|
| **Name of Business Associate** | |
| **Address** | |
| **Business Associate Contact Name** | |
| **Business Associate Contact Telephone** | |
| **Business Associate Contact E-mail** | |
| **Type of Covered Entity** | |

## Section 3 – Breach Information

| | |
|---|---|
| **Date of Breach** | |
| **Date of Breach Discovery** | |
| **Approximate number of individuals affected by the Breach** | |
| **Type of Breach** | **Please check all that apply**<br>☐ Theft ☐ Improper disposal<br>☐ Loss ☐ Unauthorized Access<br>☐ Hacking/IT Incident<br>☐ Other (Please describe)<br>_____<br>_____ |
| **Location of Breach Information** | **Please check all that apply**<br>☐ Laptop ☐ Desktop Computer<br>☐ Network Server ☐ E-mail<br>☐ Other portable Electronic Device<br>[Please identify other electronic device(s)]<br>_____<br>_____ |
| **Type of Protected Health Information involved in the Breach** | **Please check all that apply**<br>☐ Demographic Information<br>☐ Financial Information<br>☐ Clinical Information<br>☐ Other<br>Describe information in detail in section below |
| **Brief Description of the Breach**<br>Include the location of breach, how the breach occurred, and any additional information regarding the type of breach, type of media, and type of Protected Health Information involved in the breach. | |
| **Safeguards in Place prior to the Breach** | **Please check all that apply**<br>☐ Firewalls<br>☐ Packet Filtering (router-based)<br>☐ Secure Browser sessions<br>☐ Strong Authentication<br>☐ Encrypted Wireless |

## Section 4 – Notice of Breach and Actions Taken

| | |
|---|---|
| **Date(s) Individual Notice(s) Provided** | |
| **Was Substitute Notice required?** | ☐ **Yes** ☐ **No** |
| **Was Media Notice Required?** | ☐ **Yes** ☐ **No** |
| **Actions Taken in Response to Breach** | ☐ Security and/or Privacy Safeguards<br>☐ Mitigation<br>☐ Sanctions<br>☐ Policies and Procedures<br>☐ Other (describe "actions" in section below) |
| **Describe "Other" Actions Taken**<br><br>Please describe in detail any actions taken – in addition to those selected above – following the breach | _____<br>_____<br>_____<br>_____ |

## Section 5 – Attestation

Under the Freedom of Information Act (5 U.S.C. §552) and HHS regulations at 45 C.F.R. Part 5, OCR may be required to release information provided in your breach notification. For breaches affecting more than 500 individuals, some of the information provided on this form will be made publicly available by posting on the HHS web site pursuant to § 13402(e)(4) of the Health Information Technology for Economic and Clinical Health (HITECH) Act (Pub. L. 111-5). Additionally, OCR will use this information, pursuant to § 13402(i) of the HITECH Act, to provide an annual report to Congress regarding the number and nature of breaches that are reported each year and the actions taken to respond to such breaches. OCR will make every effort, as permitted by law, to protect information that identifies individuals or that, if release, could constitute a clearly unwarranted invasion of personal privacy.

**I attest, to the best of my knowledge, that the above information is accurate.**

_____ _____

Authorized Signature Date

# DOCUMENTATION OF RISK ASSESSMENT ASSOCIATED WITH BREACH OF PHI

It has been determined that certain protected health information (PHI) may have been acquired, accessed, used, and/or disclosed in violation of the standards established under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA). Section 164.402 of the Rule requires that if a "breach" in the protection of Protected Health Information is discovered, a harm threshold Risk Assessment must be conducted and documented.

The Assessment is used to determine (1) if a breach in the protection of PHI has occurred, (2) if the security or privacy of protected health information has been compromised, (3) the level of harm to the patient(s), if any, that the unauthorized use or disclosure of their PHI may cause, and (4) what mitigating actions have been/should be taken in response to the matter.

| **Assessment Report Type** | ☐ Initial Assessment | ☐ Addendum to initial Assessment |
|---|---|---|

## Section 1 – Covered Entity

| | |
|---|---|
| **Name of Covered Entity** | **Roosevelt Dental Center of Skagit County** |
| **Address** | **Mount Vernon, Washington 98273** |
| **Contact Name** | **Hailey Johnson** |
| **Contact Telephone** | **360-424-5650** |

## Section 2 – Business Associate

Complete this section only if the breach occurred
at or by a Business Associate

| | |
|---|---|
| **Name of Business Associate** | |
| **Address** | |
| **Business Associate Contact Name** | |
| **Business Associate Contact Telephone** | |

## Section 3 – Breach Information

| | |
|---|---|
| **Date of Breach** | |
| **Date of Breach Discovery** | |
| **Approximate number of individuals affected by the Breach** | |
| **Type of Breach** | **Please check all that apply**<br>☐ Theft ☐ Improper disposal<br>☐ Loss ☐ Unauthorized Access<br>☐ Hacking/IT Incident<br>☐ Other (Please describe)<br>_____<br>_____<br>_____ |
| **Location of Breach Information** | **Please check all that apply**<br>☐ Laptop ☐ Desktop Computer<br>☐ Network Server ☐ E-mail<br>☐ Other portable Electronic Device<br>[Please identify other electronic device(s)]<br>_____<br>_____ |
| **Type of Protected Health Information involved in the Breach** | **Please check all that apply**<br>☐ Demographic Information<br>☐ Financial Information<br>☐ Clinical Information<br>☐ Other<br>Describe information in detail in section below |
| **Brief Description of the Breach**<br>Include the location of breach, how the breach occurred, and any additional information regarding the type of breach, type of media, and type of Protected Health Information involved in the breach. | _____<br>_____<br>_____ |
| **Safeguards in Place prior to the Breach** | **Please check all that apply**<br>☐ Firewalls<br>☐ Packet Filtering (router-based)<br>☐ Secure Browser sessions<br>☐ Strong Authentication<br>☐ Encrypted Wireless |

## Section 4 – Notice of Breach and Actions Taken

| | |
|---|---|
| **Individual responsible for breach** | ☐ Employee<br>☐ Patient<br>☐ Hacker<br>☐ Burglar<br>☐ Other_____ |
| **Name of responsible party** (if known) | _____<br>_____<br>_____ |
| **Was breach inadvertent?** | ☐ **Yes** ☐ **No** |
| **Was breach deliberate or premeditated** | ☐ **Yes** ☐ **No** |
| **Was PHI acquired, accessed, or used without authorization?** | ☐ **Yes** ☐ **No** |
| **Was PHI disclosed inappropriately or without authorization?** | ☐ **Yes** ☐ **No** |
| **To whom was PHI disclosed?** | _____<br>_____<br>_____ |
| **Was the PHI disclosed to another Covered Entity?** | ☐ **Yes** ☐ **No** |
| **Was the PHI service/procedure specific?** | ☐ **Yes** ☐ **No** ☐ **Not known** |
| **Can disclosure result in identity Theft of patients whose PHI was accessed?** | ☐ **Yes** ☐ **No** ☐ **Not known** |
| **Was PHI returned?** | ☐ **Yes** ☐ **No** |
| **Was PHI returned prior to inappropriate use or disclosure?** | ☐ **Yes** ☐ **No** |
| **Can unauthorized disclosure of the PHI be harmful to the patient(s)** | ☐ **Yes** ☐ **No** ☐ **Not known** |

# Roosevelt Dental Center of Skagit County



## Section 4 – Breach Determination

| | |
|---|---|
| **Has a Breach of protected Health Information has occurred?** | ☐ **Yes** ☐ **No** |
| **If "Yes" what actions have been taken in response to the breach?** | ☐ **Security and/or Privacy Safeguards**<br>☐ **Mitigation**<br>☐ **Sanctions**<br>☐ **Policies and Procedures**<br>☐ **Other** (describe "actions" in section below) |
| **If "Yes" were all patients affected by the Breach" notified?** | ☐ **Yes** ☐ **No** |
| **Was Health and Human Services notified?** | ☐ **Yes** ☐ **No, not required.** |
| **Was the media notified?** | ☐ **Yes** ☐ **No, not required.** |
| **Has the matter been resolved and concluded?** | ☐ **Yes** ☐ **No** |
| **Have all necessary parties been notified of the breach determination and resolution?** | ☐ **Yes** ☐ **No** |
| **Describe "Other" Actions Taken**<br>Please describe in detail any actions taken – in addition to those selected above - following the breach | _____<br>_____<br>_____<br>_____ |

## Section 5 - Attestation

**I attest, to the best of my knowledge, that the above information is accurate.**

_____ _____

**Amanda Rentschler, DDS** **Date**

# Roosevelt Dental Center of Skagit County



## EQUIPMENT AND MEDIA INVENTORY

| Equipment Type | Brand Name | Model Number | Serial Number | Location |
|---|---|---|---|---|
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# Roosevelt Dental Center of Skagit County



## EPHI ACCESS LEVEL DETERMINATION

| Employee Name | Job Classification | Access Level (Check all that apply) | | | |
|---|---|---|---|---|---|
| | | Patient Schedule | Treatment Records | Insurance Data | Financial Records |
| | | | | | |
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# Roosevelt Dental Center of Skagit County



## SECURITY THREAT EVALUATION

| Nature of Threat | Steps Taken to Eliminate or Minimize Threat |
|---|---|
| **Describe all potential threats to the security or integrity of PHI in your practice** | **Describe the steps your practice takes to minimize or eliminate each threat** |
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# Roosevelt Dental Center of Skagit County



## SECURITY INCIDENT REPORT

| | | | |
|---|---|---|---|
| **Name of Person Reporting Security Incident** | | | |
| **Job Classification** | | **Today's Date** | |
| **Date of incident (if known)** | | **Date of Discovery** | |
| **Were police notified?** | ☐ **YES** ☐ **NO** | **Notification Date** | |

### NATURE OF SECURITY INCIDENT

| | |
|---|---|
| ☐ **Unauthorized electronic access/hacking** | ☐ **Unauthorized access to facility's computers** |
| ☐ **Loss of back-up media** | ☐ **Theft of back-up media** |
| ☐ **Computer virus or spyware detected** | ☐ **Violation of clearance access level by employee** |
| ☐ **Loss of computer hardware containing EPHI** | ☐ **Theft of computer hardware containing EPHI** |
| ☐ **Break-in or other violation of building security** | ☐ **Fire** |
| ☐ **Natural disaster** | ☐ **Water damage** |
| ☐ **Other:** | |

**Describe the incident:**

**How was it discovered?**

**Who witnessed the incident?**

**How was EPHI affected?**

**How was the affect on EPHI mitigated, and by whom?**

| | | |
|---|---|---|
| **Signature of person filing report** | | **Date:** |
| **Signature of Security Officer** | | **Date:** |

# Roosevelt Dental Center of Skagit County



## VENDOR VISITOR CONFIDENTIALITY AGREEMENT

| | | | |
|---|---|---|---|
| **Roosevelt Dental Center of Skagit County** | | | |
| **1210 Roosevelt Ave** | | | |
| **Mount Vernon** | | **Washington** | **98273** |
| **Visitor Name** | | | |
| **Visitor's Company** | | | **Telephone** |
| **Visitor's Company Address** | **Street Address** | | |
| | **City** | **State** | **Zip code** |

### VISITOR AFFILIATION

| | |
|---|---|
| ☐ **Delivery** | ☐ **Sales Representative** |
| ☐ **Health Care Supply** | ☐ **Janitorial Service** |
| ☐ **Maintenance** | ☐ **Security Systems or Service** |
| ☐ **Contracted Temporary Employee** | ☐ **Computer Support** |
| ☐ **Other (describe)** | |

### PURPOSE OF VISIT

### CONFIDENTIALITY STATEMENT

As a visitor to this practice, I understand that my activities are limited to those minimally necessary for the purpose of my visit(s) as described above. I am specifically restricted from accessing, inspecting, using, or disclosing any confidential information encountered in this facility without prior authorization from the practice's privacy or security officer. I understand that any Protected Health Information (PHI) to which I may be exposed is confidential and may not be disclosed or shared. I further understand that any unauthorized disclosure of PHI is a violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other Federal and State laws, and I understand and acknowledge that any such violation subjects me to criminal and civil prosecution and penalties including fines and imprisonment.

***I certify that I have read and understand the Confidentiality Statement printed above.***

VISITOR NAME _____ SIGNATURE _____ DATE _____

# Roosevelt Dental Center of Skagit County



## VENDOR TECHNICAL COMPLIANCE STATEMENT

| | |
|---|---|
| **Vendor Company** | |
| **Vendor Address** | |
| **Vendor Telephone** | |
| **Vendor e-mail** | |
| **Type of Service Provided** | |
| **Authorized Representative** | |

The Health Insurance Portability and Accountability act of 1996 (HIPAA) provides for the protection of patient healthcare information (PHI). To ensure the protection of PHI, HIPAA requires that all devices and media used to collect, store, access or transmit PHI in electronic form meet certain technical requirements.

It is the intention of this practice to comply fully with the requirements of HIPAA and rely only on vendors who commit to providing equipment and services that meet those requirements.

Your signature below certifies that you understand the technical requirements of HIPAA and agree that all equipment and/or services provided will conform to those requirements.

I hereby attest and affirm that all computer hardware and software installed and maintained in this practice will fully conform to the technical requirements of the Health Insurance Portability and Accountability Act of 1996.

_____ _____

Authorized signature Date

_____

Please print representative's signature

# Roosevelt Dental Center of Skagit County



## SERVICE PROVIDER CONTACT LIST

| Company | Representative | Telephone | Service Provided |
|---|---|---|---|
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