JOHNSON COUNTY COMMUNITY COLLEGE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Part 1: **Name of person whose health information will be disclosed:** *[please print]*

Part 2: **Person or Entity that has the health information to be released:**

❒ Johnson County Community College
❒ Johnson County Community College Flexible Benefits Plan
❒ Other: _____ *[please print the name of the entity that has the record to be disclosed; e.g., Dr. Jane Doe, XYZ Insurance Company, ABC Laboratories, etc.]*

Part 3: **Description of the health information to be released:**

❒ Lab results (including drug screening and blood-alcohol test results)
❒ Psychiatric/psychological evaluation
❒ Physical examination results and notes
❒ History, treatment and progress notes
❒ Other: _____ *[describe the health information that may be disclosed]*

Are the records to be released limited to records created during a **specific period of time**: ❒ No ❒ Yes
If "Yes" indicate specific time period: From *[insert date]* to *[insert date]*

Part 4: **Person or Entity that will receive the health information:**

❒ Johnson County Community College
❒ Johnson County Community College Flexible Benefits Plan
❒ Other: *[please print the name of the entity that will receive the record]*:

Part 5: **Description of the purpose for the release of the health information:**

❒ At the request of the person whose name appears in Box 1
❒ Pre-employment or periodic controlled substance screen or psychoanalysis evaluation
❒ Other *[insert description of the purpose]*:

Part 6: **Duration of Authorization:** This Authorization will remain effective *[choose an expiration period or event]*:

Expiration period: ❒ 30 days ❒ 60 days ❒ 90 days ❒ 180 days ❒ ___ days

Expiration event: *[insert description of an event upon which the Authorization will expire]*:

Part 7: **Certification and Acknowledgement:** I certify that I am the person (or the personal representative of the person) designated in Part 1. I agree that my individually identifiable health information described in Part 3, and held by the person or entity listed in Part 2, may be disclosed to the person or entity listed in Part 4 for the purpose(s) designated in Part 5. ***I understand that, if the information to be disclosed is needed by a health care plan in order to determine my eligibility for plan benefits; or is needed by Johnson County Community College to consider me for medical, sick or other leave; or to consider my eligibility or claim for short- or long-term disability or life insurance coverage or benefits, workers' compensation benefits, or similar fringe benefits; or to consider me for employment or continued employment, my failure to provide this Authorization may prevent me from receiving the benefit or leave, or preclude me from being considered for employment or continued employment.*** I understand that I have the right to revoke this Authorization, in writing, at any time, by sending the revocation to the person or entity who received the Authorization, and that the revocation will be effective except to the extent that the person or entity releasing the information has already taken action in reliance on my Authorization. I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under federal privacy rules. ***I have received a copy of my signed Authorization.***

Signature: _____ **Date:** _____

[If signing as the personal representative of the person in Box 1, print your name and describe your authority to sign for the person]:
Name: _____ Authority: _____

For office use:
❒ Authorization fully completed and signed
❒ Copy of Authorization provided to Individual or Personal Representative

JOHNSON COUNTY COMMUNITY COLLEGE

PROTECTED HEALTH INFORMATION
DISCLOSURE REQUEST FORM

This Form is used by individuals and others to request disclosure of protected health information ("PHI") in the possession of the health care plans sponsored or maintained by Johnson County Community College and any of its affiliates, or the business associates of such plans. ***Submit this Form to the Human Resources Department****.*

REQUESTER:
(Print name, address, telephone number, and date)

Name:
Address:
SSN or Plan Enroll. Number:
Telephone number: Date:

INFORMATION REQUESTED:
(Describe the information you're requesting)

REASON FOR REQUEST:
(Describe reasons you're requesting the information)

AUTHORITY:
(If requesting information on behalf of an individual, describe your authority to act for the individual)

ACTION ON REQUEST:

Request is: ❒ Approved ❒ Disapproved because: _____
_____
_____

Privacy Official/Deputy Privacy Official certification: *Initial here:* _____ *Date:* _____

For office use only:

Request received: ❒ in writing ❒ orally
Requester's identity and authority verified: ❒ No ❒ Yes _____*(Initial)*
Date received: _____ Recipient name: _____ Date delivered to Privacy Official/ Deputy:_____
Transmittal to Business Associate *(if appropriate)*: Date: _____ Name of Business Associate: _____

Authorization Issues:

Authorization is: ❒ Required ❒ Not required because disclosure is for: ❒ TPO ❒ Other reason:
_____

If Authorization is required, is Authorization provided and valid? ❒ N/A ❒ No ❒ Yes *(If Yes, attach to this Form)*

Approval/disapproval:

If request is **disapproved:**

Notify the requester by returning a copy of this Form. Form returned on *(insert date)*: _____

If request is **approved:**

Is the disclosure for one of the reasons below: ❒ No ❒ Yes *(if Yes, check appropriate box below)*

❒ To the individual ❒ Required by law
❒ Pursuant to authorization ❒ To Dept. of HHS
❒ To a provider for treatment ❒ Required for compliance with HIPAA data standards

If disclosure is NOT for a reason above, a "minimum necessary" analysis is required. ***Disclose only the minimum necessary.*** If request is from other plan or provider, or a law enforcement/public official for an official purpose, generally you may presume the amount requested is the amount needed. See the Privacy Policy and Procedure Manual.

Documentation Requirements:

Is the disclosure for TPO, required by law, or to law enforcement? ❒ Yes ❒ No *(If No, disclosure may have to be logged; see the Privacy Policy and Procedure Manual.)*

Keep a copy of this Form

JOHNSON COUNTY COMMUNITY COLLEGE

FORM TO REQUEST ACCESS TO AND AMENDMENT OF PROTECTED HEALTH INFORMATION MAINTAINED IN A DESIGNATED RECORD SET

*This Form is used by individuals to request access to, and amendment of, their protected health information ("PHI") in a Designated Record Set in the possession of the health care plans sponsored or maintained by Johnson County Community College and any of its affiliates, or the business associates of such plans. Use **Part 1** to request access to PHI, use **Part 2** to request amendments of PHI.*
***Submit this Form to the Human Resources Department**.*

REQUESTER:
(Print name, address, telephone number and date)

Name:
Address:

Telephone number: Date:

PART 1 - REQUEST FOR ACCESS

REQUEST FOR ACCESS TO PHI:

Please describe the protected health information ("PHI") to which you would like access. We will not provide access to PHI that is not maintained in a Designated Record Set, nor to psychotherapy notes or information complied in reasonable anticipation of civil, criminal or administrative proceeding. If we grant your request we will arrange with you a mutually convenient time to review your records. We may make a reasonable charge for copying (including labor) and postage.

ACTION ON REQUEST:

The request is: ❒ Approved ❒ Disapproved due to _____
_____
_____
_____

You ❒ have ❒ do not have a right to appeal this denial.

If you have a right to appeal, the initial denial will be reviewed by a licensed health care professional who is designated by the Privacy Official or his or her designee. You may also file a complaint with the Deputy Privacy Official by submitting the complaint to the Human Resources Department (complaint forms are available from HR). The Deputy Privacy Official may be reached at _____. You may also file a complaint with the Secretary of the federal Department of Health and Human Services.

Privacy Official/Deputy Privacy Official certification: *Initial here:* _____ *Date:* _____

For office use only:

***Receipt*:**
Date: _____ Recipient name: _____ Date delivered to Privacy Official/ Deputy:_____

Transmittal to Business Associate *(if appropriate)*: Date: _____ Name of Business Associate: _____

Response deadline: Records on site - 30 days from filing: _____ Records off site - 60 days from filing: _____*

Approval/disapproval:
Notify the requester of action on this request by returning a copy of this Form. Form returned on *(insert date)*: _____. If request is approved, coordinate with the person making this request to arrange a time and place to review the requested records.

Documentation:
Keep a copy of this Form.

* *See Privacy Policy and Procedure Manual for information about extensions, and about procedures for handling consideration of these requests, and appeals.*

PART 2 - REQUEST FOR AMENDMENT OF PHI

REQUEST FOR AMENDMENT OF PHI:

Please describe the protected health information ("PHI") you desire to amend, and the nature of the amendment you would like to make.

ACTION ON REQUEST:

The request is: ❒ Approved ❒ Disapproved due to _____
_____
_____
_____

You have a right to appeal this denial by submitting a letter of disagreement or appeal to the Privacy Official or Deputy Privacy Official, in care of the Human Resources Department. If you do not wish to submit a letter of disagreement or an appeal, you may request in writing that this Form, showing your request for amendment, be attached to the records you wish to amend, so that when the records are disclosed in the future your request for amendment is also made available to the person who receives the records.

You may also file a complaint with the Deputy Privacy Official by submitting the complaint to the Human Resources Department (complaint forms are available from HR). The Deputy Privacy Official may be reached at _____. You may also file a complaint with the Secretary of the federal Department of Health and Human Services.

Privacy Official/Deputy Privacy Official certification: *Initial here:* _____ *Date:* _____

For office use only:

***Receipt*:**

Date: _____ Recipient name: _____ Date delivered to Privacy Official/ Deputy:_____

Transmittal to Business Associate *(if appropriate)*: Date: _____ Name of Business Associate: _____

Response deadline: 60 days from filing: _____ *

Approval/disapproval:

Notify the requester of action on this request by returning a copy of this Form. Form returned on *(insert date)*: _____.
If request is approved, implement the requested amendment in accordance with the procedures described in the Privacy Policy and Procedure Manual.

Documentation:
Keep a copy of this Form.

* *See Privacy Policy and Procedure Manual for information about extensions, and about procedures for handling consideration of these requests, and appeals.*

JOHNSON COUNTY COMMUNITY COLLEGE

FORM TO REQUEST ADDITIONAL RESTRICTIONS ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Form is used by individuals to request additional restrictions on their protected health information ("PHI") in the possession of the health care plans sponsored or maintained by Johnson County Community College and any of its affiliates, or the business associates of such plans. This Form is also used to request that certain disclosures of PHI by the plans or their business associates be made via reasonable, alternative means. ***Submit this Form to the Human Resources Department****.*

REQUESTER:
(Print name, address, telephone number and date)

Name:
Address:

Telephone number: Date:

REQUEST FOR ADDITIONAL RESTRICTION ON USE OR DISCLOSURE OF PHI:

Please describe the circumstances or contexts in which you would like disclosures of your PHI restricted. ***NOTE:*** *You may only request that your PHI be restricted for purposes of treatment, payment and health care operations, and/or when disclosure would otherwise be made to family members and close friends involved in your care, or for purposes of notification of your condition or location. We are not required to agree to your request.*

REQUEST TO RECEIVE CERTAIN DISCLOSURES OF PHI BY ALTERNATIVE MEANS:

Please describe why you desire to receive communications of PHI from the Plan via alternative methods, and the methods by which you would like to receive the communications. Your statement should clearly indicate that the alternative method is required to avoid endangering you. We are required to agree to your request but ONLY if it is reasonable, and ONLY if failure to do so would endanger you.

ACTION ON REQUEST:

Request is: ❒ Approved ❒ Disapproved

Privacy Official/Deputy Privacy Official certification: *Initial here:* _____ *Date:* _____

For office use only:

***Receipt*:**
Date: _____ Recipient name: _____ Date delivered to Privacy Official/ Deputy:_____

Approval/disapproval:
If request is **disapproved:** **N**otify the requester by returning a copy of this Form. Form returned on *(insert date)*: _____

Implementation:
If request is **approved**, implement the agreed upon restriction or confidential communication method.

Termination of Restriction:
Restrictions may be terminated in writing or orally by requester, or by the Plan (after providing notice of the termination). If the restriction is terminated, complete the following:

Restriction is terminated by: ❒ Requester via written notice *(attach notice)* ❒ Requester orally ❒ Plan
Privacy Official/Deputy Privacy Official certification: *Initial here:* _____ *Date:* _____

Documentation:
Keep a copy of this Form

JOHNSON COUNTY COMMUNITY COLLEGE

FORM TO DESCRIBE COMPLAINT REGARDING HANDLING OF PROTECTED HEALTH INFORMATION

This Form is used by individuals to register complaints concerning the handling of their protected health information ("PHI") in the possession of the health care plans sponsored or maintained by Johnson County Community College and any of its affiliates, or the business associates of such plans. ***Submit this Form to the Human Resources Department****. Federal law prohibits Johnson County Community College, its affiliates, and business associates from retaliating against you for filing this complaint.*

COMPLAINANT:
(Print name, address, telephone number and date)

Name:
Address:

Telephone number: Date:

NATURE OF COMPLAINT:

Please describe your complaint. Please be as specific as you can with respect to the details, including names of persons involved (if known), dates, locations, and specific actions or omissions. Write on the back of this sheet, or attach additional sheets, if necessary.

For office use only:

***Receipt*:**
Date: _____ Recipient name: _____ Date delivered to Privacy Official/ Deputy:_____

Investigation:
The Privacy Official or his or her designee must investigate this complaint. The investigation should be documented, and its conclusions reduced to writing. Where warranted, the Privacy Official should direct appropriate remedial action, and impose appropriate sanctions.

Report to Complainant:
The results of the investigation (whether the complaint should prove unfounded or accurate) should be communicated to the complainant (sanctions against persons or other entities need not be revealed).

Complainant notified: *(insert date)*: _____

Privacy Official/Deputy Privacy Official certification: *Initial here:* _____ *Date:* _____

Keep a copy of this Form