HIPAA PRIVACY RULE
SUGGESTED ELEMENTS AND EXAMPLES
FOR JOB CORPS CENTER OPERATING PROCEDURES

The National Office of the Job Corps has prepared this document to assist Job Corps contractors in complying with their responsibilities regarding protected health information (PHI) under the Privacy Rule (Rule) of the Health Insurance Portability and Accountability Act (HIPAA). This document contains suggestions for the contents of a Job Corps Center's written policies and procedures on the Rule. The Rule requires each covered entity – which at minimum includes health and wellness centers (HWC) at each Center – to develop and maintain written policies and procedures to implement the Rule. *Contractors and subcontractors are urged to consult legal counsel in preparing their policies and procedures*.

Additional information about implementing the HIPAA Privacy Rule at Job Corps Centers can be found in Job Corps Program Instruction No. 02-19 (April 4, 2003), in Job Corps PRH Change Notice No. 02-05 (June 2, 2003), and on the Health and Wellness Program website to assist Job Corps Centers (http://www.jobcorpshealth.com).

Disclaimer

The suggested elements and examples provided in this document:

- Do not take into account state laws. Each Center must abide by any state laws that provide greater privacy protections or privacy rights for the individual whose health information is involved, for example, regarding drug test and HIV results.
- Do not take into account the operations of any particular contractor. We make no representation that this checklist or any part of it will be legally sufficient as to any particular contractor or situation.
- Do not address compliance with other federal laws or regulations, such as the Privacy Act of 1974 or disability/civil rights laws. Job Corps contractors must continue to comply with those requirements, as in the past, unless there is a clear conflict with the Rule. In the case of a conflict, the law or regulation more protective of student rights should be followed.
- Do not provide significant guidance as to which uses and disclosures of student health information are permitted by the Rule. Permissible uses and disclosures of student health information that HWCs may make (without obtaining a specific student okay), such as those for treatment, payment, and health care operations, should be listed in each center's Notice (discussed in Element 13). Determining which uses are permissible requires reference to the Rule and possibly the technical assistance resources available through www.hhs.gov/ocr/hipaa. Permissible uses and disclosures should be part of the required Job Corps HIPAA training. All uses and disclosures are limited by the permissible purposes of the uses or disclosure. The "minimum necessary" discussions in this checklist (Elements 7, 8, 9) contemplate using or disclosing the minimum information necessary to accomplish permissible purposes only.

Many Job Corps contractors have asked for a fill-in-the-blank form. We have considered the matter carefully and have concluded that such a form is not likely to be legally correct as applied to a specific contractor due to the variations in Center operations nationwide and in state laws. However, we have provided sample language for some elements of a standard operating procedure. Generally, the documentation and retention portions of the sample language are mandatory, while the process portions are mere format examples (although whatever process you choose should be documented). For instance, in Element 4, the Rule requires that all

sanctions applied against members of the workforce who fail to comply with privacy policies and procedures be documented. However, the Rule does not require that the Health and Wellness Manager (HWM) and the Privacy Officer agree that a privacy violation has occurred, although obviously *some* non-arbitrary system should be created to determine whether discipline is warranted.

In a number of the suggested elements, reference is made to keeping documents for at least 6 years. We understand that storing this additional paperwork will be a burden on Centers, but it is a legal requirement. Some of these documents may contain proprietary information, such as agreements with business associates, and should be safeguarded while being retained for the 6-year period. The Rule does not require that documents be retained on Center premises, so long as the HWC still has control over the documents and can make them available for the entire 6-year period. That is, the HWM can retrieve the medical record from archives if necessary. Nothing prevents HWCs from sending these documents along with the Medical Folders to another location to be stored for the Center (archives).

These Center operating procedure elements are just EXAMPLES. Each Privacy Officer should adapt them to fit the Center's particular needs.

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1. Designate the entity.

- Identify all covered entities.

- Determine whether it is appropriate to designate one or more health care components to create a hybrid entity. (Hybrid entities consist of both covered health care components and other components. For example, a Center contractor might have within it a health care unit, a vocational education unit, and a food service unit). Designate the health care components of the hybrid entity and list all jobs or functions that are included in the component (includes covered functions such as the direct provision of health care, as well as related functions requiring student health information, such as clerical or administrative functions). For designated hybrid entities, only the health care component must comply with most aspects of the Rule. However, the larger entity remains responsible for ensuring that the health care component complies with the Rule.

- Since the medical records of separated students are sent to another part of the Center to be stored for 3 years, that records area should be included in the "health care component." Alternatively, although this would involve some work in asking students to sign another version of the standard Authorization, Centers could revise the existing Authorization to state, "We may transfer your medical records to the Student Records staff for the purpose of meeting Privacy Rule document retention requirements and for providing storage for your records until they are forwarded to the Department of Labor under Job Corps records retention requirements." This statement could be added as a separate numbered paragraph in the existing list of numbered paragraphs. (The National Office of Job Corps intends to revise the standard Authorization to include this paragraph, but this will not cover students who have already signed the existing Authorization form.)

- If appropriate, designate an organized health care arrangement (OHCA). For example, a clinically integrated care setting involving more than one health care provider may be designated as an OHCA. Also, an OHCA could involve participation by various covered and non-covered entities or health care components, including quality review personnel such as Regional Health Consultants.

- List all staff positions designated as a part of the OHCA (or other covered entity).

  Example
  "ABC Center Operator, Dental Associates, Inc., Mental Health Unlimited, Inc., and the Office of A. Kumar, M.D. are identified as covered entities at XYZ Job Corps Center. ABC Center Operator is designated as a hybrid entity. The portion of ABC Center Operator that operates the Health and Wellness Center (HWC), plus the Student Records area, is designated as the health care component. The health care component consists of the HWC management, clerical staff, and TEAP functions, as well as Student Records functions. The HWC is designated as an organized health care arrangement (OHCA) consisting of the following entities: (1) the health care component of ABC Center Operator; (2) Dental Associates, Inc.; (3) Mental Health Unlimited, Inc.; (4) office of A. Kumar, M.D.; (5) Kelly Temporary Receptionists, Inc.; and (6) Regional Health

Consultants. The staff positions designated as a part of the OHCA are: CMHC, TEAP, Center Dentist, Hygienist, Center Physician, Nurses, Medical Technicians, Laboratory Technicians, Clerical Staff, Health and Wellness Administrators, and Regional Health Consultants."

2. Designate privacy staff.

- Designate a Privacy Officer and describe the functions/responsibilities of the Privacy Officer in developing and implementing privacy policies and procedures.

- Designate a contact person or office for receiving complaints and providing information.

Example

"The OHCA (HWC) Privacy Officer is Jane Smith. The Privacy Officer is responsible for developing and implementing HWC Privacy Rule policies and procedures. This includes writing the HWC Privacy Handbook and reviewing it annually for necessary changes; developing a Privacy Rule training protocol and ensuring that all HWC members are trained accordingly; creating and implementing a periodic Privacy Rule review process to ensure that policies described in the Privacy Handbook are being followed; and creating and implementing a disciplinary process for staff violations of those policies and procedures.

The Complaint Officer is John Doe. The Complaint Officer is responsible for receiving complaints alleging privacy violations. In addition, the Complaint Officer is responsible for answering questions and providing information about the Privacy Rule."

3. Describe how the Center will process complaints, including complaint documentation and 6-year retention.

The Rule requires a complaint process, complaint documentation, and 6-year retention of complaint records. However, the complaint process described below is only a format example; you are free to create and describe a different complaint process.

Example

"Privacy Rule complaints may be made either to the HWC or to the U.S. Department of Health and Human Services (HHS), as described in the Notice. HWC complaints should be in writing directed to the Complaint Officer. The Complaint Officer will receive complaints, investigate them, and provide a written decision to the complainant within 30 days of the complaint. If the decision denies the complaint, the decision document will provide for appeal rights to the Center Director within 30 days of the denial. The Center Director will provide a written decision on the matter within 30 days of receiving an appeal. The Complaint Officer will document all complaints and their dispositions by creating a complaint file that includes the following information: name of complainant, date of complaint, office or person receiving the complaint, copy of the complaint, description of investigatory steps taken, copy and date of Complaint Officer decision letter, copy and date of appeal letter (if applicable), and copy and date of Center Director decision letter (if applicable). This file must be retained in the HWC for 6 years after the disposition of the complaint."

4. **Describe sanctions available against HWC staff members who violate the Center's privacy operating procedures and how you will document any sanctions actually applied.**

   Centers may choose to describe their normal disciplinary procedures for privacy violations or create a new system. Note that the Rule does not mandate the specific types of discipline described in the Example below or the process for awarding discipline or documenting sanctions. However, the Rule requires that sanctions be appropriate and documented, and that record of the sanctions be retained for 6 years.

   Example
   "Any HWC staff member found, by the concurrence of both the HWM and the Privacy Officer, to have violated these procedures will be given an oral warning by the HWM and counseled by the Privacy Officer. Upon a second offense within the same calendar year, the HWM will give the staff member a written warning, with a copy in his/her personnel file, and will require the staff person to re-take the annual Privacy Rule training. Upon a third offense within the same calendar year, the HWM will give the staff member a suspension of one to three days, depending on the seriousness of the offense as judged by the HWM. Four offenses within a single calendar year are grounds for termination of the staff member from the HWC. Documentation of all warnings, suspensions, and terminations for privacy violations will be noted in the Privacy Rule Compliance Log. A new log will be started every calendar year. The logs will be kept in the HWM's office with other confidential personnel materials and retained for 6 years after the last offense noted in a particular year's log."

5. **Identify business associates and describe the business associate contract requirement.**

   Business associates are people or entities that perform a function for or provide a service to the covered entity and require protected health information (PHI) to do that job. (Members of an OHCA, such as a Center Receptionist, and all direct and indirect health care providers treating the student, such as Center mental health providers and dental labs, are not business associates of each other, unless there is some other service relationship between them.) HWCs are not permitted to disclose PHI to business associates without a contract that contains privacy protections. Certain language is required to be in this contract and sample contract language is available at http://www.hhs.gov/ocr/hipaa/contractprov.html. Business associate contracts must be retained for 6 years after the expiration of the contract.

   The following is an example only. While the Rule requires that business associate agreements be in place in order to share PHI, and that they be retained for 6 years, nothing mandates the specific process described for ensuring that the agreements occur.

   Example
   "The HWC is required to have a business associate contract that includes privacy protections with any person or business that uses HWC PHI to perform a service for the HWC. Historically, our HWC has shared PHI with businesses providing the following services to us: records archiving, accounting, and quality control. Currently, we have business associate relationships with the following firms: LMN Archiving and CDE Accountants. The HWM is responsible for ensuring that the HWC has a business associate contract on file in the HWC for all business associates. The Privacy Officer shall assist the HWM, as necessary, in creating valid business associate agreements. No HWC staff

member shall disclose PHI to a business associate unless there is a business associate contract on file in the HWC. Business associate contracts must be retained in the HWC file room for 6 years after the expiration of the contract."

6. Describe the training program.

The Rule requires that all staff of the covered entity receive training on the Rule "as necessary and appropriate." Job Corps requires that all workforce members of the covered entity (for example, the HWC OHCA) be trained on the policies and procedures with respect to PHI yearly, and all new staff be trained within 90 days, and has published training materials available on www.jobcorpshealth.com. Further, if there is a material change in a HWC's privacy policies, all staff members affected should be trained on that change within a reasonable time. The fact of the training should be documented, and that documentation should be stored for 6 years. Not all staff members need to receive the same training, so long as the training is "necessary and appropriate for the members of the workforce to carry out their function within the covered entity."

Example

"These policies require privacy training appropriate to the functions of HWC staff members. All members of the HWC must have annual training on these policies. Training will be scheduled in April of each year, with make-up training sessions to be announced. Additional training will occur on a case-by-case basis if there is a change in these policies that affects any staff member's job. All new staff members must be trained within 90 days of their starting dates. The Training Coordinator will be responsible for scheduling training and instructors, determining the training that is appropriate for each HWC staff position, and documenting that each person has had the required training. This training log must include the following: name of staff member, date of training, identification of training modules, and staff member initials certifying completion of training. Training logs should be retained in the HWC for 6 years after the completion of training."

7. "Minimum necessary: "Describe staff access to and uses of records that contain protected health information.

Identify each HWC position that requires permissible access to PHI to carry out the duties of that position. For each position that needs access, describe the categories of PHI needed and identify any conditions under which that position needs access. (Example: "The TEAP Specialist should be informed of lab test results if a student tests positive for illegal drugs.") Also, for each position that needs access, describe whether the position needs access to all the records (the entire file) or only certain sections. If access to the complete file is needed, provide a specific justification why the entire file is reasonably necessary to accomplish the purpose of the access. Health care providers could have access to all medical records for treatment purposes, but this must be part of the policy.

Example

"The File Clerk should have access to the entire folder only for purposes of appropriately placing it in the HWC records area, retrieving it for appointments, and filing information. The following positions have access to the entire folder for treatment purposes so as to make sound medical decisions and to avoid negative interactions among various treatments or prescriptions: CMHC, Center Dentist, Hygienist, Center Physician, Nurses, Medical Technicians, and Laboratory Technicians. The Regional Health Consultants have access to

the entire folder for the purpose of reviewing appropriateness of care, compliance with Job Corps rules, standards of care, and other assessments. Access to the entire folder is needed for these assessments because the Department of Labor requires the Regional Health Consultants to conduct an evaluation of all medical services provided to students during their tenure with Job Corps."

8. **"Minimum necessary: "Describe procedures for making both routine and non-routine disclosures of PHI to persons/entities outside the HWC.**

   For routine or recurring disclosures, such as weekly, monthly, or annual reports, create standard protocols for each type of disclosure that are designed to disclose only what is needed to accomplish the purpose of that report. Once protocols are created, each individual report does not need to be separately reviewed by a privacy reviewer as long as the protocol is followed.

   Example
   "Significant Incident Reports (SIRs) will include only the following health information: diagnosis, condition, treatment actions taken, and prognosis. Since the purpose of SIRs is to report significant incidents to the Department of Labor for its administrative oversight activities, health information unrelated to the incident will not be included in these reports."

   For non-routine disclosures, create similar limiting criteria (so that only what is needed will be disclosed), ***plus*** designate someone to review each disclosure individually to ensure minimum necessary disclosure. In the case of requests, the reviewer should verify the identity and authority of the requester.

   For both types of disclosures, generally you must have specific justification to share a student's entire medical folder. **However, you do not need to have any procedures, protocols, or reviews when sharing PHI (including the entire folder) with an outside health care provider for treatment purposes.**

   Example
   "Proposed responses to all outside requests for disclosure and all non-routine disclosures initiated by the HWC should be reviewed by the HWM. In responding to requests, the HWM is responsible for verifying the identity of the requester and his/her authority to obtain PHI, and ensuring that only the information necessary to respond to the request is disclosed."

9. **"Minimum necessary: "Describe procedures for making requests for PHI from others.**

   For routine or recurring requests, create standard protocols that limit the PHI you request to the amount reasonably necessary. For all other requests, describe criteria designed to limit the request to the information reasonably necessary, and provide for a review process (non-routine requests must be reviewed individually to ensure what is being requested is reasonably necessary).

   Generally, you must have a specific justification in order to request all of a student's medical records from an outside provider. **However, you do not need to create procedures, criteria, or review processes for HWC health care providers who request PHI from an outside source for treatment purposes.** "Minimum necessary" does not apply to providers obtaining information from others for treatment purposes.

10. Identify which disclosures must be documented and what information should be included in that documentation, and describe a process for maintaining a disclosure log.

The Rule requires that you document certain kinds of disclosures, and that you then provide this information when students request an "Accounting of Disclosures" (as discussed under Element 11 below). To make it easier to prepare this Accounting, and although not required by the Rule, we suggest that you create a process for maintaining an accessible, organized Disclosure Log that covers those disclosures for which documentation is required. You could have one separate log organized alphabetically by student name, or else each student folder could have a section of Disclosure Log Sheets in which the required information is documented chronologically. Whatever process you create, you should include an accountability review in which supervisors check the logs to ensure that public health and other types of recordable disclosures actually are being put into the log. The documentation must be retained for 6 years (since students can request the documentation for the prior 6 years).

Disclosures do not need to be documented if they are:

- for TPO (treatment, payment, health care operations),
- under an authorization (including the standard Authorization required of all Job Corps students),
- to individuals about themselves,
- "incident to" an allowed disclosure,
- for a facility directory or for certain care or notification purposes,
- for national security/intelligence purposes,
- to correctional institutions or other custodial situations,
- part of a "limited data set" (excludes identifiers) for research, public health, or health care operations, or
- disclosures that occurred prior to April 14, 2003.

The following disclosures (among others) must be documented:

- notifying a public health authority (CDC, state health department, etc.) about a condition,
- disclosures to law enforcement or in response to a court order or subpoena,
- disclosures to HHS or another health oversight agency (many DOL disclosures, however, may also be either payment or health care operations disclosures and would not need to be documented),
- disclosures to OSHA or other public health agencies,
- disclosures to a coroner or funeral director about a decedent,
- disclosures for cadaver donation purposes,
- disclosures for certain research purposes,
- any OWCP disclosures that do not fall under "payment" or "health care operations" disclosures,
- disclosures to the Armed Forces about a service member, and
- disclosures to avert a serious threat to health or safety.

In any of these examples, if the disclosure ***also*** falls under TPO or one of the other exemptions, it does not need to be documented. If a disclosure must be documented, that documentation must include: (1) the date of the disclosure; (2) the name (and address if known) of the entity/person receiving the PHI; (3) a brief description of the PHI; and (4) a brief statement of the purpose for disclosure.

11. Describe procedures for handling requests by students for an Accounting of Disclosures, including the title of the person/office responsible for processing requests.

The Rule requires most aspects of the following example, including the timeframes, designation of request processor, one free Accounting per year, cost-based fees only, documentation, and retention provisions. However, nothing requires that the HWM be designated as the request processor, that fees be discretionary for the HWM, or that the storage location be the HWC file room.

Example

"All student requests for an Accounting of Disclosures should be forwarded to the HWM for processing. All disclosures of the requesting student's health information as recorded in the Disclosure Log, up to 6 years prior to the request (if that time period is requested), must be included in a written Accounting given to the student. The Accounting must be given to the student within 60 days of the request. One 30-day extension is allowed if, within the first 60 days, the student is given a written statement of reasons for the delay and the date by which he/she will be given the Accounting. Students are entitled to at least one free Accounting per year. At his/her discretion, the HWM may approve a fee of [INSERT COST-BASED FIGURE] per page (of which the student should be informed upon making the request) for second and subsequent requests by the same student within a 12-month period. The name and title of the person responsible for providing the written Accounting (for example, the HWM) should be noted on a copy of the Accounting, and this copy should be stored in the HWC file room for 6 years."

12. Describe administrative, technical, and physical safeguards for preventing unauthorized access.

The Rule requires that the HWC have appropriate administrative, technical, and physical safeguards to protect health information from intentional or unintentional disclosures that are not permitted by the Rule, and to avoid incidental disclosures. The following safeguards discussion comes from the www.hhs.gov/ocr/hipaa FAQs:

Covered entities must evaluate what measures make sense in their environment and tailor their practices and safeguards to their particular circumstances.

The following examples of possible safeguards are not intended to be exclusive. Covered entities may engage in any practice that reasonably safeguards PHI to limit incidental uses and disclosures. Computer password protection, locked filing cabinets, and desk clean-up policies are other examples of safeguards that may be reasonable.

Example

“The Privacy Rule does not prohibit covered entities from engaging in the following practices, where reasonable precautions have been taken to protect an individual’s privacy:

- Maintaining patient charts at bedside or outside of exam rooms, displaying patient names on the outside of patient charts, or displaying patient care signs (e.g., “high fall risk” or “diabetic diet”) at patient bedside or at the doors of hospital rooms. Possible safeguards may include: reasonably limiting access to these areas, ensuring that the area is supervised, escorting non-employees in the area, or placing patient charts in

their holders with identifying information facing the wall or otherwise covered, rather than having health information about the patient visible to anyone who walks by.

- Announcing patient names and other information over a facility's public announcement system. Possible safeguards may include: limiting the information disclosed over the system, such as referring the patients to a reception desk where they can receive further instructions in a more confidential manner.

- Use of X-ray lightboards or in-patient logs, such as whiteboards, at a nursing station. Possible safeguards may include: if the X-ray lightboard is in an area generally not accessible by the public, or if the nursing station whiteboard is not readily visible to the public, or any other safeguard which reasonably limits incidental disclosures to the general public."

13. Notice: Describe procedures for giving students the Notice and revising the Notice as necessary.

The HWC must identify in the Notice all uses and disclosures of student health information that the HWC actually makes from among the disclosures that the Rule permits to be made without student authorization. The Notice must be given to students on their first visit to the HWC. Permitted uses and disclosures include those for treatment, payment, health care operations, disclosures required by law and for health oversight activities, and other uses listed in the Rule. Centers should not simply adopt the sample Notice posted on www.jobcorpshealth.com, but should revise it to reflect permissible uses and disclosures that the HWC actually makes of student health information. The Notice must be updated before a new permissible use or disclosure is put in place, or another key term of the Notice is changed.

Much of the following example is mandatory, including the provider giving the Notice to the student, the fact that the Notice also must be posted and available for distribution to anyone, the receipt or documentation in lieu of receipt, the non-mandatory nature of the receipt, the need to immediately post revisions, and the retention requirements. However, nothing requires HWCs to install a bulletin board next to the reception desk (could be another prominent location), or to direct student questions to the receptionist (could be another person), or the HWM to be responsible for reviewing the Notice annually, although *someone* needs to ensure the Notice is accurate.

Example

"The HWM will ensure that a copy of the Notice is mailed to all parents/guardians of minor students, and will document that mailing, including the date and address to which the Notice was sent, in each student's Medical Folder. In addition, whenever a HWC provider sees a student (adult or minor), the HWC provider shall review the Medical Folder to determine whether a signed receipt of Notice, or a notation verifying the student received the Notice, is in the folder. If no receipt or notation is present, the provider will give a copy of the Notice to the student and request that he/she sign the receipt. The receipt should be placed in the student folder. THE STUDENT DOES NOT HAVE TO SIGN THE RECEIPT. If the student declines to sign the receipt, the provider should make a notation in the folder that he/she provided the Notice to the student on that date, and the student declined to sign. Student questions about the Notice may be directed to the HWC Receptionist. The Notice will be posted on the bulletin board next to the reception desk, and the Receptionist will keep extra copies for distribution to anyone who asks for one (even non-students). The HWM is

responsible for reviewing the Notice in April of each year to ensure that it includes ALL uses of student information for treatment, payment, and health care operations, and other uses for which student authorization is not required. THE HWC MAY NOT SHARE STUDENT HEALTH INFORMATION EXCEPT AS DESCRIBED IN THE NOTICE OR AUTHORIZATION. Therefore, for uses not requiring student authorization, the Notice ***must*** be revised immediately if it does not include a needed use of student health information. All revisions should include the revision date. Students do not need to be given the revised Notice individually if they received a copy of the original Notice, but the Receptionist should take down the old Notice immediately and post the new Notice on the bulletin board, and keep copies of the revised Notice for distribution. At least one copy of each old Notice must be kept in the HWC file room until 6 years after it was revised. Receipts of Notice and notations in lieu of receipts must be kept by the HWC for 6 years."

14. Authorizations Describe the process for obtaining and retaining Authorizations.

While specific wording may vary, most of the concepts in the following example are required, due to a combination of the Rule and Job Corps policy.

Example

"The Job Corps standard Authorization is required for all students, and must be placed in the student's Medical Folder. The HWC is prohibited from disclosing information as described in the Authorization, including the results of drug screens, without a signed Authorization. Students who do not have a standard Authorization on file should be asked to sign one. Any student refusing to sign the standard Authorization should be referred to the Center Director for case-by-case evaluation. If the Center Director determines that the student's situation, due to imminent graduation or other circumstances, is such that the lack of an Authorization will not impede Center operations, the Center Director need not discharge the student from Job Corps. Authorizations in addition to the required Job Corps standard Authorization are voluntary. If the HWC or a Center believes a supplemental Authorization is necessary [Attachment C of Program Instruction No. 02-19; see also www.jobcorpshealth.com], the Regional Office should be consulted for approval to require this supplemental Authorization as a condition of continued enrollment. The HWC may not require a supplemental Authorization as a condition of treatment. Authorizations must be retained in the HWC for 6 years."

15. Describe what constitutes the "designated record set" and the process for student access, including the title of the person/office responsible for processing requests for access.

Students may access their PHI contained in the "designated record set." The record set designated must include all medical and billing records about a student, and any other information maintained by the HWC that is used to make decisions about students. This includes records sent to storage facilities to be stored on behalf of the Center. However, when student records are transferred to the Department of Labor, they are no longer being maintained by the Center, so student requests for their information under the HIPAA Privacy Rule would not reach those transferred records. However, students may still make Privacy Act requests for those records (requests under the Privacy Act of 1974, which is how students have been able to access their records in the past).

While the specific designation of the HWC Receptionist is not required, the Rule allows or requires most of the other aspects of the following example, including exclusion of mental health counseling notes, reasonable cost-based fees, timeframes, denials, written notifications, and appeals.

Example

"The 'designated record set' to which students may have access is the Medical Folder and any other record containing PHI that is used to make decisions about students, including Medical Folders or other records stored at XYZ Archiving, Inc. A student is entitled to access and get copies of the PHI in this record set, no matter how old the information. Any mental health professional not wanting a student to obtain access to personal counseling notes (the notes taken during or analyzing conversations in the actual counseling sessions) should not place those notes in the Medical Folder (or other records). Student requests for copies of or access to Medical Folders (or other health records) should be directed to the HWC Receptionist. A fee of [INSERT COST-BASED FIGURE] per page may be charged to the student for copies of the Medical Folder or other health records. Copies or access must be provided within 30 days (60 days if some of the information is off-Center), with one 30-day extension allowed if the student is given an advance written reason for the delay and the anticipated response date. Under very limited circumstances, access to some parts of the Medical Folder (or other health records) may be denied, such as when a HWC health care provider determines that the information is likely to endanger the student or another person. Consult the Privacy Officer if there is a denial question. In the rare cases in which student access may be denied, some denials are appealable. Consult the Privacy Officer before making any denials to ensure legal basis and proper notification to the student, including notification of appeal rights in some cases. In the case of an appealable denial, and if the student appeals, the HWM will arrange for an uninvolved health professional to review the request and determine which records, if any, should be released to the student."

16. Describe the process for allowing students to request an amendment to their Medical Folders (or other health records), and identify the title of the person/office responsible for processing amendment requests.

While specific designation of the HWM is not required, the Rule does require the concepts described in the following example.

Example

"Students are entitled to ask the HWC to amend information in their Medical Folders. The HWM is responsible for receiving and processing amendment requests. The HWC must act on requested amendments within 60 days, with one 30-day extension possible if the student is notified in advance in writing, stating the reason and the date the HWC will act on the request. If the HWC accepts the change, the HWC must: attach or otherwise link the amendment to the HWC record(s) at issue, notify the student, and notify any persons either identified by the student or that the HWC knows could rely on the incorrect information. The HWC may deny the request if the information the student proposes to change already is accurate and complete, or for other limited reasons (see Privacy Officer for details). In that case, the HWM should notify the student in writing of the denial, within the designated time period. A denial must contain the following:

- The basis for the denial
- A statement of the student's right to submit a written statement disagreeing with the denial and how the student may file such a statement

- A statement that, if the student does not submit a disagreement, the student has the right to request that the HWC provide the student's request for amendment and the denial along with any future disclosures of the disputed PHI
- A description of how the individual may complain to the HWC or to the U.S. Secretary of Health and Human Services.

If the student files a disagreement statement, the HWC may also include in the Medical Folder a rebuttal statement responding to the student. The HWC must give the student a copy of any rebuttal.

For any information in a Medical Folder that is disputed, the HWM should attach to it the amendment request, the acceptance or denial, any disagreement the student submitted, and any HWC rebuttal to the disputed information. Persons accessing that information should be given those dispute documents as well."

17. Describe miscellaneous documentation requirements.

While specific wording may vary, and nothing requires the HWM, specifically, to decide on restriction requests, the Rule does require most of the other concepts in the following example.

Example

"A student may request that the HWC not share certain information that is described in the Notice. (For example, a female student may not want it disclosed that she is pregnant.) The HWM may agree to such a restriction, but is not required to agree. (However, certain requests, such as a request not to disclose that a student is suicidal must NOT be agreed to.) If the HWM agrees to the restriction, that restriction must be documented in the student's Medical Folder and retained for 6 years. If a restriction is noted in a student's Medical Folder, all HWC staff must comply with that restriction (except that the restricted information can be used or shared if necessary for emergency treatment of the student).

This Privacy Rule Operating Procedures Handbook must be dated upon publication and retained for 6 years. All changes to privacy policies and procedures, including changes in the titles of persons or offices responsible for various subject areas as described in this handbook, should be documented by revising this handbook. All revised versions should contain the date of revision. When the handbook is revised, a copy of the old version must be saved in the HWC file room for 6 years after the revision. At any point in time, an outside observer should be able to determine the policies in effect currently ***and*** all the policies that were in effect over the past 6 years."

18. Describe mitigation, non-retaliation, and non-waiver requirements.

The Rule requires covered entities to try to undo or reduce any harm caused by a privacy violation by a staff member, requires staff members not to intimidate or punish students for exercising their rights under the Rule, filing a privacy complaint, or participating in a privacy proceeding, and forbids entities from asking students, as a condition of treatment, to waive their privacy rights, including their right to complain to HHS.