

 SACVALLEY MEDSHARE	PROCEDURE: <i>Uses and Disclosures of Health Information Procedure</i>	PROCEDURE NUMBER: <i>SVMS-PRO-005.003</i>
	Author: Elizabeth L Steffen	Origination Date: 01/15/2015
	Revised By: Elizabeth L Steffen	Revised Date: 12/02/2016

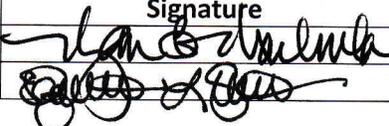
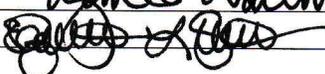
Purpose:

The purpose of the Uses and Disclosure of Health Information procedure is to ensure that requests for disclosures are processed correctly, effectively, efficiently, and in accordance with all state and federal regulations.

Procedure:

Accounting of Disclosures

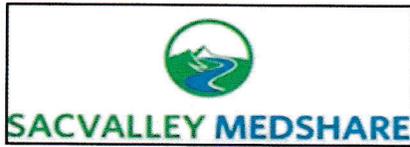
1. Receive request.
 - a. By phone, direct requestor to www.sacvalleyms.org and to download and complete the Request for Accounting of Disclosures form English (Attachment A, a Microsoft® Word® document, and also as a PDF, SVMS-FORM-016) or Spanish (Attachment B, a Microsoft® Word® document, and also as a PDF, SVMS-FORM-021), and to send the request back via electronic mail to info@sacvalleymedshare.org, or via postal mail to SacValley MedShare, P.O. Box 9217, Chico, CA 95927-9217.
 - b. By postal mail or electronic mail, continue to step 2.
2. Log the request on the Accounting of Disclosures Log (Attachment E, a Microsoft® Excel® worksheet, SVMS-FORM-017).
3. Fill out the Accounting of Disclosures Form (Attachment C, a Microsoft® Word® document, SVMS-FORM-015) or Spanish (Attachment D, a Microsoft® Word® document, SVMS-FORM-022).
4. Sign and date the form.
5. Scan to Box.
6. Mail the original to the requestor via certified postal mail with return receipt requested.
7. Must be retained for a period of no less than 6 (six) years from the date of request.
8. All original documents are to be forwarded to Myron Machula at Enloe for housing.

Authorization	Name	Signature	Date
Board Chair	Myron E. Machula		4/6/2017
Project Manager	Elizabeth Steffen		03.31.2017

Reference:

- California Medical Association. (2010). *Accounting of Disclosures Forms*.
- Seneca Healthcare District Release of PHI – Documentation – Retroactive Accounting of Disclosures Policy. (2013, August).
- Seneca Healthcare District Accounting of Disclosures Form. (2014, December).
- The University of Montana. (2004, July). *Accounting of Disclosures*. Retrieved January 15, 2015 from http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.umt.edu%2Fresearch%2Fcompliance%2FHIPAA%2FHIPAAccountingPolicy.doc&ei=pU24VIOwGoSuyQTijoDwAg&usq=AFQjCNF5EXuQJVeU2Q3VSb8d59M0_Ahrug&bvm=bv.83829542,d.aWw

Attachment(s):



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Author: Elizabeth L Steffen	Origination Date: 01/15/2015
Revised By: Elizabeth L Steffen	Revised Date: 12/02/2016

- A: *Request for Accounting of Disclosures English (3 pages) (page 3)*
- B: *Request for Accounting of Disclosures Spanish (3 pages) (page 6)*
- C: *Accounting of Disclosures English (2 pages) (page 9)*
- D: *Accounting of Disclosures Spanish (2 pages) (page 11)*
- E: *Accounting of Disclosures Log (1 page) (page 13)*

Version	Date	Author	Comment
.001	07/09/2015	E. Steffen	Initial release.
.002	12/15/2015	E. Steffen	Updated address in body of procedure and on attachments.
.003	12/02/2016	E. Steffen	Original documentation send to location.

 SACVALLEY MEDSHARE	PROCEDURE: <i>Uses and Disclosures of Health Information Procedure</i>	PROCEDURE NUMBER: SVMS-PRO-005.003
	Author: Elizabeth L Steffen Revised By: Elizabeth L Steffen	Origination Date: 01/15/2015 Revised Date: 12/02/2016

Attachment A: Request for Accounting of Disclosures – Page 1



**SACVALLEY
MEDSHARE**

The Health Information Exchange
for California's North Central Valley
P.O. Box 9217
Chico, CA 95927-9217

Request for Accounting of Disclosures

Date: _____ Date of Birth: _____ MR#: _____

Patient Name: _____

I would like an accounting of how my protected health information was disclosed by SacValley MedShare, as required by federal regulations. I understand that the HIE does not have to tell me about the following types of disclosures:

- Disclosures for purposes of treatment, payment, and healthcare operations or as part of a limited data set.
- Disclosures to me or disclosures authorized by me.
- Disclosures for use in the HIE's directory.
- Disclosures to persons involved in my care.
- For notification purposes (to notify a family member, personal representative, or other person of my location, general condition, or death).
- For national security or intelligence purposes.
- To correctional institutions or law enforcement officials.
- Disclosures made prior to: _____
- Disclosures incident to a use or disclosure otherwise permitted or required by federal law.

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

I want an accounting of disclosures that covers the following time period:

NOTE: The time period must be no longer than 6 (six) years.

SVMS FORM 01/02/15 Request for an Accounting of Disclosures - English Page 1 of 3

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Attachment A: Request for Accounting of Disclosures – Page 3



**SACVALLEY
MEDSHARE**

The Health Information Exchange
for California's North Central Valley
P.O. Box 9217
Chico, CA 95927-9217

Request for Accounting of Disclosures

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.sacvalleymedshare.org, or by sending a written request to SacValley MedShare, P.O. Box 9217, Chico CA 95927-9217.

If you believe your privacy has been violated, you may file a complaint with SacValley MedShare or with the Secretary of the United States Department of Health and Human Services. To file a complaint with SacValley MedShare, send an e-mail to info@sacvalleymedshare.org or by sending a written complaint to SacValley MedShare, P.O. Box 9217, Chico CA 95927-9217.

You will not be penalized for filing a complaint.

SVMS-FORM-EN-002: Request for an Accounting of Disclosures - English
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Attachment B: Request for Accounting of Disclosures Spanish – Page 1



SACVALLEY MEDSHARE

El Intercambio de Información de Salud para el Valle Central del Norte de California
 P.O. Box 9217
 Chico, CA 95927-9217

Solicitud de Informe de Divulgaciones

Fecha: _____ Fecha de Nacimiento: _____
 Expediente Médico#: _____
 Nombre del Paciente: _____

Me gustaría recibir una explicación de cómo mi información de salud protegida se ha dado a conocer por SacValley MedShare (HIE), así como las estipulaciones requeridas por las regulaciones federales. Entiendo que el HIE no tiene que dejarme saber sobre los siguientes tipos de revelaciones:

- Divulgaciones para fines de tratamiento, pago y operaciones de atención médica o como parte de un conjunto de datos limitados.
- Revelaciones o divulgaciones autorizadas por mí.
- Revelaciones para el uso del directorio de el HIE.
 Divulgaciones a personas involucradas en mi cuidado médico.
- A los efectos de notificación (para notificar a un miembro de la familia, representante personal, u a otra persona acerca de mi ubicación, condición general o muerte).
 Por razones de seguridad nacional o de inteligencia.
- Para instituciones correccionales o funcionarios encargados de hacer cumplir la ley.
- Revelaciones hechas antes del: _____
- Revelaciones incidentales a una utilización o divulgación permitidas o requeridas por la ley federal.

También entiendo mis derechos a recibir una explicación de algunas o todas las divulgaciones puede ser suspendidas por el gobierno en circunstancias limitadas.

Quiero un informe de las revelaciones que cubre el siguiente periodo de tiempo:

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Attachment B: Request for Accounting of Disclosures Spanish – Page 2

El Intercambio de Información de Salud para el Valle Central del Norte de California
 P.O. Box 9217
 Chico, CA 95927-9217

Solicitud de Informe de Divulgaciones

Quiero recibir el informe de las revelaciones de la siguiente forma:

en papel

Quiero que la contabilidad me sea enviada. Favor de enviar a la siguiente dirección:

dirección _____ ciudad _____ estado _____ cremallera _____

electrónicamente

Por favor de enviarme un correo electrónico a la siguiente dirección:

_____ @ _____
 Dirección de Correo Electrónico

Entiendo que el HIE me debe dar el informe de las revelaciones dentro de los 60 (sesenta) días, o dejarme saber que necesito tiempo adicional dentro de 30 (treinta) días (o menos) para prepararlo.

Tengo el derecho a una contabilidad libre de costo por las revelaciones en cualquier periodo de 12 meses. Las contabilidades adicionales costarán \$ _____ cada una.

Fecha: _____ Hora: _____ AM/PM

Firma: _____

Si es firmado por alguien que no sea el paciente, indique su relación: _____

Imprimir Nombre: _____
 (representante legal)

Por favor, escanear y enviar por correo electrónico a: info@sacvalleymedshare.org –
 OR-
 mail a: SacValley MedShare, P.O. Box 9217, Chico CA 95927-9217

SVMS-FORM 021.002 Request for an Accounting of Disclosures - Spanish
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Attachment B: Request for Accounting of Disclosures Spanish – Page 3



SACVALLEY MEDSHARE

El Intercambio de Información de la
Salud para Valle Central Norte de
California
P.O. Box 9217
Chico, CA 95927-9217

Solicitud de Informe de Divulgaciones

Para obtener más información acerca de sus derechos de privacidad, consulte el "Aviso de prácticas de privacidad", disponible en nuestro sitio web el www.sacvalleymedshare.org, o mediante el envío de un escrito solicitud a SacValley MedShare, P.O. Box 9217, Chico CA 95927-9217.

Si usted cree que su privacidad ha sido violada, puede presentar una queja ante SacValley MedShare o con el Secretario del Departamento de Salud de los Estados Unidos y Servicios Humanos. Para presentar una queja ante SacValley MedShare, envíe un e-mail a info@sacvalleymedshare.org o mediante el envío de una queja por escrito a SacValley MedShare, P.O. Box 9217, Chico CA 95927-9217.

Usted no será penalizado por presentar una queja.

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Attachment C: Accounting of Disclosures - Page 1



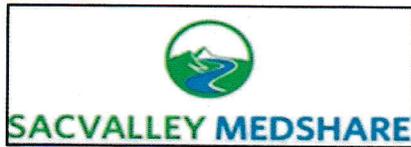
Sac Valley MedShare, P.O. Box 9217, Chico, CA 95927-9217

ACCOUNTING OF DISCLOSURES

Patient Name: _____ MR#: _____
 Date of Request: _____

TYPE OF DISCLOSURE	DISCLOSED TO (PERSON/ENTITY)	DATE OF DISCLOSURE	BRIEF DESCRIPTION OF DISCLOSURE
Civil or criminal investigations			
California Medical Review			
Court Orders/ Warrants			
Billing			
Grand Jury Subpoena			
Subpoena or discovery request not accompanied by court order or patient authorization			
Worker's Comp Subpoenas			
Law Enforcement if Crime suspected			
Crime suspected on premises			
Identifying, locating a suspect/ fugitive			
Child abuse/neglect (CPS)			
Elder abuse/neglect (APS)			
Reporting of sexual assault			
Injuries by firearms			
Injuries by assault/abusive conduct (see Penal Code 1160)			
Animal bites			
Violent acts against hospital employees (Health & Safety Code 1257.7)			
Cancer Registries			

SVMS-FORM-025.002 Accounting of Disclosures - English Page 1 of 2



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Attachment C: Accounting of Disclosures - Page 2

Tumor Registries			
Trauma Registries			
Births			
Deaths			
Coroners/Medical Examiners			
Funeral Directors			
Burny/Smoke Inhalation injuries (H&S Code 13110.7)			
Northern California Transplant Bank			
Public Health Oversight			
Department of Motor Vehicles (lapses of consciousness)			
To avert a serious threat to health or safety of patient, identified target, or the public			
Inappropriate/inadvertent disclosures: Fax to incorrect number, inappropriate verbal discussions, unlawful disclosures.			

_____ <i>Name & Signature of Processor</i>	_____ <i>Date</i>
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SVMS FORM-015.002 Accounting of Disclosures - English Page 2 of 2



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Attachment D: Accounting of Disclosures Spanish – Page 1



Sac Valley MedShare, P.O. Box 9217, Chico, CA 95927-0217

DIVULGACIÓN DE CONTABILIDAD

Fecha de nacimiento: _____ MR#: _____
 Fecha de la solicitud: _____

TIPO DE DIVULGACIÓN	Compartida con (PERSONA / ENTIDAD)	FECHA DE DIVULGACIÓN	BREVE DESCRIPCIÓN DE LA DIVULGACIÓN
Investigaciones Civiles o Penales			
Revisión Médica - California			
Orden del Tribunal/ Garantizada			
Facturación			
Citación del Gran Jurado			
Solicitud de Citación o Descubrimiento no Acompañada por una Orden Judicial o Autorización del Paciente			
Citaciones de Compensación del Trabajador			
Aplicación de la Ley si se Sospecha de un Crimen			
Sospechada de Crímenes Locales			
Identificación, Localización de un Sospechoso / Fugitivo			
Abuso o Descuido (CPS)			
Abuso/Negligencia (APS) de Persona Mayor			
Denuncia de Agresión Sexual			
Lesiones por Armas de Fuego			
Lesiones por Asalto/Conducta Abusiva			

SVMS-FORM-022.002 Accounting of Disclosures - Spanish Page 1 of 2



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Attachment D: Accounting of Disclosures Spanish – Page 2

(Código Penal 1160)			
Mordeduras por Animales			
Actos Violentos Contra los Empleados de un Hospital (Código de Salud y Seguridad 1257.7)			
Registros de Cáncer			
Registros de Tumores			
Registros de Trauma			
Nacimientos			
Muertes			
Médicos Examinadores Forenses			
Directores de Funerarias			
Lesiones de Quemaduras o Inhalación de humo (H & S código 13110.7)			
Banco de Trasplante del Norte de California			
Supervisión de Salud Pública			
Departamento de Vehículos Motorizados (Lapsos de Conciencia)			
Para Evitar una Amenaza Grave de salud o Seguridad al Paciente Identificado o Público			
Divulgación Inadecuada/Inadvertida: Fax al Número Incorrecto, discusiones verbales Inadecuadas o Accesos Ilegales.			

Name and Signature of Processor

Date

SVMS-FORM-022.002 Accounting of Disclosures - Spanish Page 2 of 2



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Attachment E: Accounting of Disclosures Log

 Accounting of Disclosures Log										
Participant	Date Received	Received By	FORM 016 completed	Date Form 016 completed	Form Verified By	Date Form 016 verified	Form mailed (certified)	Return Receipt Received	Notes	
<i>Dr. John</i>	<i>1/12/2015</i>	<i>KP</i>	<i>Y</i>	<i>1/15/2015</i>	<i>ES</i>	<i>1/18/2015</i>	<i>1/19/2015</i>	<i>1/25/2015</i>	<i>None</i>	<i>Example</i>