Policy and Procedure: *HIPAA/HITECH Compliance*
Topic: *Disclosure Accounting Request Processing*

HIPAA Regulation:

- *Disclosure Accounting* § 164.528

Policy Purpose:

The purpose of this policy is to provide individuals an accounting of disclosures of protected health information in accordance with the HIPAA requirements.

Policy Description:

It is the policy of Saratoga Bridges that an accounting of all disclosures subject to such accounting of protected health information (PHI), in accordance with the Health Information Portability and Accountability Act (HIPAA), be provided to individuals or their personal representatives whenever such an accounting is requested.

Policy Responsibilities:

Organization Staff

1. Forwards all requests for disclosure accounting to the Privacy Officer**.**

Privacy Officer

1. Contacts the individual or personal representative who requests a disclosure accounting within five business days of the request.
2. Informs the individual or his/her personal representative that the Organization requires the request to be documented and submitted using the Request for Accounting of Disclosures of Protected Health Information form.
3. Provides the requestor with a copy of the form, offering assistance as necessary.
4. Reviews Request for Accounting of Disclosures of Protected Health Information form, verifying that the accounting is valid and includes only health information disclosures that are required to be accounted for by HIPAA. (See NOTE below)
5. Reviews the request to determine if a law enforcement official has requested that disclosures to the law enforcement organization not be included in an accounting of disclosures at this time. (If so, omits the relevant disclosures from the disclosure accounting.)
6. Reviews the records and compiles a list of every disclosure for the period of six years prior to the date of request subject to an accounting.

7. Ensures that each entry contains:
    a. The date of the disclosure.
    b. The name of the entity or person who received the protected health information and, if known, the address of such entity or person.
    c. A brief description of the protected health information disclosed.
    d. A brief statement of the purpose for each disclosure.
8. If many disclosures were made to the same entity for the same purpose, it is permissible to group them together by providing the following:
    a. The information identified above.
    b. How frequently or how many times the information was disclosed.
    c. The date of the last such disclosure.
9. Provides the completed Accounting of Disclosures form to the individual or personal representative.
10. Files the request and the completed Request for Accounting of Disclosures form in the Organization's HIPAA compliance file.

NOTE:

The following disclosures of PHI are not subject to an accounting:

- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures made to the individuals about them.
- Disclosures made to persons involved in the individual's care.
- Disclosures made for national security or intelligence purposes.
- Disclosures made to correctional institutions or law enforcement officials.
- Disclosures that are incident to a permitted use or disclosure.
- Disclosures made pursuant to an authorization.
- Information in the facility's directory.
- Information as part of a limited data set.

Appendix: Request for Accounting of Disclosures of Protected Health Information Form

Request for Accounting of Disclosures of Protected Health Information

Saratoga Bridges
16 Saratoga Bridges Blvd. Ballston Spa, NY 12020
Privacy Officer: Julianne Furlong Phone: (518) 871-9483

As required by the Health Insurance Portability and Accountability Act, you have a right to request an accounting of disclosures of health information that pertains to you.

REQUEST SECTION

I, _____ (print name), hereby request an accounting of disclosures of protected health information pertaining to me (or the individual identified below) that have occurred over the last six (6) years.

Signed: _____ Date: _____
Print Name: _____ Telephone: _____
If not signed by the Individual, please indicate:

Relationship:

- ☐ Parent or guardian of individual
- ☐ Health Care Proxy or Agent
- ☐ Beneficiary or personal representative of deceased individual (i.e., parent, guardian, healthcare proxy, etc.)
- ☐ Other (specify) _____

Name of Individual: _____

REQUEST PROCESSING SECTION

This section is to be completed by the reviewer:

Date received:	**Reviewed by:**
Privacy Officer:	**Review Date:**

The requested disclosure accounting was processed on _____ (Date)

_____ _____
Print Name Title

_____ _____
Signature Date