Eye Surgery Center of Western Ohio
Access to Protected Health Information Policy and Procedure

Introduction

Eye Surgery Center of Western Ohio, LLC, has adopted this Patient Access to Protected Health Information ("PHI") Policy and Procedure to comply with our responsibility to protect individually identifiable health information and the system components that such data resides in under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Department of Health and Human Services ("DHHS") security and privacy regulations implementing HIPAA, the HITECH Act, other federal and state laws protecting confidentiality of health information, and business associate contracts that we have entered into. All personnel of Eye Surgery Center of Western Ohio, LLC, must comply with this Patient Access to Protected Health Information Policy and Procedure. Demonstrated competence in the requirements of this Patient Access to Protected Health Information Policy and Procedure is an important part of every Eye Surgery Center of Western Ohio, LLC, employee's responsibilities.

Assumptions

This Patient Access to Protected Health Information Policy and Procedure is based on the following assumptions:

- Eye Surgery Center of Western Ohio, LLC, has a duty to protect individually identifiable health information and the system components that such data resides in under HIPAA, among other laws, rules, and regulations.
- Eye Surgery Center of Western Ohio, LLC, has a duty to provide patients access to their protected health information ("PHI") under HIPAA, among other laws, rules, and regulations.

Definitions

The following definitions apply to this Patient Access to Protected Health Information Policy and Procedure:

- **Abstract (summary):** Brief summary on Eye Surgery Center of Western Ohio, LLC, letterhead of the essential information as requested on a proper form.
- **Designated record set:** Group of any records under the control of a covered entity from which PHI is retrieved by the name of the individual or by identifying number.
- **Direct access:** In-person review of the medical record and/or obtaining a copy of the record.
- **Disclosure of PHI summary:** Accounting of disclosures of PHI (in paper or electronic format) containing the following: date of disclosure; name and address of the organization or person who received the PHI; brief description of the information disclosed; purpose for which the PHI was disclosed.
- **Licensed health care professional:** Clinician that has been licensed by the appropriate licensing agency in Ohio. Such professionals may be licensed physicians, psychologists, licensed clinical social workers, nurses, therapists, counselors, speech pathologists, nurse practitioners, audiologists, athletic trainers, physical therapists, physician assistants, social workers, pharmacists, and other licensed health care specialists.
- **Patient:** Any individual who has received or is receiving services from Eye Surgery Center of Western Ohio, LLC
- **Personal representative:** Person with a court order appointing that person as guardian or with a valid power of attorney signed by the patient specifying the authority to review and make decisions regarding medical, psychiatric, therapy treatment, or habilitation counseling concerns.

- **Protected health information ("PHI"):** Individually identifiable health information, including demographic information, collected from an individual that:
  - Is created or received by a health care provider, health prescription plan, employer, or health care and pharmacy clearinghouse; and
  - Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual, and
  - Identifies the individual, or with respect to which, there is reasonable basis to believe that the information can be used to identify the individual.
- **Psychotherapy notes:** Notes recorded in any medium by a health care provider that is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Such notes exclude medication prescriptions and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Policy

- The policy of Eye Surgery Center of Western Ohio, LLC, is to protect individually identifiable health information and the system components that such data resides in under HIPAA, among other laws, rules, and regulations.
- The policy of Eye Surgery Center of Western Ohio, LLC, is to provide patients access to their protected health information ("PHI") under HIPAA, among other laws, rules, and regulations.

Procedure

- **Request for access to PHI.**
  - A patient who has or is receiving services from Eye Surgery Center of Western Ohio, LLC, a parent of a minor, and a personal representative or legal guardian of a patient should request in writing for access to inspect or receive copies of PHI except in those instances covered by federal regulations and outlined in the Eye Surgery Center of Western Ohio, LLC, Notice of Privacy Practices acknowledged at admission and must further specify the exact information requested for access. This policy does not mean that Eye Surgery Center of Western Ohio, LLC, provider cannot give a patient a copy of the patient's test results, preventive measures, care instructions, or information to assist the patient's understanding of the diagnosis during the delivery of health care without a written release.
  - The *Access to Protected Health Information Request Form* shall be provided to facilitate the process. Eye Surgery Center of Western Ohio, LLC, personnel may assist in initiating the process requesting access to PHI.
  - All requests by patients and their legal representatives for PHI must be forwarded to the Privacy Officer for action.
  - If it is acceptable after discussion with the patient, Eye Surgery Center of Western Ohio, LLC, may provide a summary of the PHI to the patient. If the summary is acceptable, Eye Surgery Center of Western Ohio, LLC, shall determine the appropriate staff to provide that explanation to the patient. The patient's agreement to a summary shall be documented in writing in the record as a check in the appropriate box in the *Access to Protected Health Information Request Form*. The patient's agreement to any costs associated with the summary shall be documented in the record. The form shall be filed in the patient's medical record.

- This request shall be processed in a timely manner according to established time frames but not more than thirty (30) days after receipt of the request. If the record cannot be accessed within the thirty (30) days, the time frame may be extended once for no more than an additional thirty (30) days with notification in writing to the individual outlining reasons for the delay and the date that the request will be concluded.

- **Denial of Access**
  - Eye Surgery Center of Western Ohio, LLC, may deny the patient access to PHI if the information requested makes reference to someone other than the patient and a health care professional has determined that the access requested is reasonably likely to cause death or serious bodily harm to that other person.
  - Eye Surgery Center of Western Ohio, LLC, may deny a request to receive a copy or inspect PHI by a personal representative of the patient if the facility has a reasonable belief that the patient has been or may be subjected to domestic violence, abuse, or neglect by such person; or treating such person as the personal representative could endanger the individual; and the facility, exercising professional judgment, decides that it is not in the best interest of the patient to treat that person as the patient's personal representative.
  - Eye Surgery Center of Western Ohio, LLC, may deny the patient access to PHI if the information requested makes reference to someone other than the patient and a health care professional has determined that the access requested is reasonably likely to cause death or serious bodily harm to that other person.
  - Requests for access to PHI may be denied provided that the individual is given a right to have the denial reviewed, except as follows.
  - Requests for Access to PHI may be denied without a right to review as follows:
    - If the information conforms to one of the following categories:
      - Psychotherapy notes.
      - HIV testing information.
      - Information compiled for use in civil, criminal, or administrative actions or proceedings.
      - Information that would be prohibited from use or disclosure under the Certified Laboratory Information Act ("CLIA") laws and regulations.
    - If the patient is participating in research-related treatment and has agreed to the denial of access to records for the duration of the study.
    - If access is otherwise precluded by law.
    - If the information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.
    - If the facility has been provided a copy of a court order from a court of competent jurisdiction that limits the release or use of PHI.
    - If a licensed health care professional based on an assessment of the particular circumstances, determines that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person.
  - Upon denial of any request for access to PHI, in whole or in part, a written letter shall be sent to the patient or other valid representative making the request for access stating in plain language the basis for the denial.
  - If the patient has a right to a review of the denial, the letter shall contain a statement of how to appeal the denial, including the name, title, address, and telephone number of the person to whom an appeal should be addressed.
  - This letter shall also address the steps to file a complaint with the Secretary of DHHS.
  - If Eye Surgery Center of Western Ohio, LLC, does not maintain the information requested, but it is known where the patient may obtain access, Eye Surgery Center of Western Ohio,

LLC, must inform the patient where to direct the request for access. The patient is to have access to records from another health care provider that are maintained in the current facility's record.

- **Appeal and Review of Denial of Requests**
  - A patient, parent of a minor, or guardian of a patient has the right to appeal the decision to withhold portions or all of the record for safety or confidentiality reasons.
  - The appeal shall be submitted in writing through the Privacy Officer, who will designate a licensed health care professional to review the denial of access.
  - The designated licensed health care professional that did not participate in the original decision to deny access shall review the record and the request for access to the patient's record. The reviewer must determine whether access meets an exception as described above.
  - If the reviewer determines that the initial denial was appropriate, the patient must be notified in writing, using plain language, that the review resulted in another denial of access. The notice must include the reasons for denial and must describe the process to make a complaint to Eye Surgery Center of Western Ohio, LLC's complaint official and/or to the Secretary of DHHS.
  - If the denial was not appropriate, the licensed health care professional who acts as the reviewer shall refer the request to the Eye Surgery Center of Western Ohio, LLC, Privacy Officer or designee for action.
  - If access is denied to any portion of the PHI, access must still be granted to those portions of the PHI that are not restricted.
  - Eye Surgery Center of Western Ohio, LLC, is bound by the decision of the reviewer.

- **Provision of Access and Fees**
  - If Eye Surgery Center of Western Ohio, LLC, provides a patient or legal representative access, in whole or in part, to protected PHI, Eye Surgery Center of Western Ohio, LLC, must comply with the specifications as outlined in federal regulations to the extent of Eye Surgery Center of Western Ohio, LLC, capabilities and as identified in Eye Surgery Center of Western Ohio, LLC's Notice of Privacy Practices.
  - Requested information must be provided in designated record sets.
  - If the requested information is maintained in more than one designated record set or in more than one location, Eye Surgery Center of Western Ohio, LLC, needs to produce the information only one time in response to the request.
  - Eye Surgery Center of Western Ohio, LLC, may provide a summary or explanation of the requested PHI if:
    - The patient agrees in advance to the summary or explanation in place of the record.
    - The patient agrees in advance to any fees imposed for the summary or explanation.
  - If the requested information is maintained electronically and the patient requests a copy or faxed copy, Eye Surgery Center of Western Ohio, LLC, should accommodate the request if possible and explain the risk to security of the information when transmitted as requested.
  - If the information is downloaded to computer disk, the patient should be advised in advance of any charges for the disk and mailing the disk.
  - If the information is not available in the format requested, Eye Surgery Center of Western Ohio, LLC, must produce a hard copy document or other format agreed upon by the patient and Eye Surgery Center of Western Ohio, LLC
  - Eye Surgery Center of Western Ohio, LLC, shall provide the access requested in a timely manner and arrange for a mutually convenient time and place for the patient to inspect the PHI or obtain copies, unless access by another method has been requested by the patient and

agreed to by Eye Surgery Center of Western Ohio, LLC, as set forth above. Any requests for accommodations shall be sent or given in writing to the Privacy Officer.
    - The fee charged will be in compliance with the current Ohio state statute and federal law. The Privacy Rule requires that any fee be reasonable and cost-based. A state fee schedule is presumed to be reasonable and cost based.
    - Unless the patient agrees otherwise, third-party documents maintained in the patient chart or other designated record set must be released along with documents created by Eye Surgery Center of Western Ohio, LLC, even if stamped "not for re-release." The only grounds for denial of access are those specified above.

- **Release of Protected PHI of a Deceased Patient.** Upon request to obtain information, the Privacy Officer shall ask for a copy of the probate court order, letters of administration, or other necessary documentation appointing the requester executor or administrator of the estate.
- The Privacy Officer is responsible for maintaining records of all requests for access to and/or copies of PHI and the action taken thereon for six (6) years from the date of the request.

Enforcement

All officers, agents, and employees of Eye Surgery Center of Western Ohio, LLC, **must** adhere to this policy and procedure, and all directors, managers, and supervisors are responsible for enforcing this policy and procedure. Eye Surgery Center of Western Ohio, LLC, will not tolerate violations of this policy and procedure. Violation of this policy and procedure is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with Eye Surgery Center of Western Ohio, LLC's Sanction Policy and personnel rules and regulations.

Name of Employee

Signature of Employee

Date signed

Eye Surgery Center of Western Ohio Access to Protected Health Information Request Form

Use this form to request access to or to receive a copy of your protected health information that Eye Surgery Center of Western Ohio, LLC., maintains regarding you.

Name: _____ Phone number: _____

Address: _____
Street City State Zip Code

Date of birth: _____ Date of request: _____

Description of records requested (please describe specific information or records requested and include time period):

Scope of request:
There is a cost-based charge for copying records as follows: The first copy is free, and there is a cost-based charge for copying records thereafter as follows: Pages 01-10: $3.51/pg, pages 11-50: $0.73/pg, Pages 51+: $0.29/pg.

- ☐ I would like to inspect the requested records.
- ☐ I would like to obtain a copy of my requested records.
- ☐ I would like both to inspect and to obtain a copy of the requested records.
- ☐ Other:

Signature of individual or personal representative: _____ Date: _____

If personal representative, describe authority and provide documentation and proof of identity:

_____

For Eye Surgery Center of Western Ohio, Privacy Officer Use Only:
Identity of individual or personal representative verified: ☐ Yes ☐ No

- ☐ Request approved.
- ☐ Request denied.
- ☐ Response delayed.

Response due date: _____
Comments:

_____
Signature of Privacy Officer Date

8/30/13
8/17/19
Rev. 8/11/22

Eye Surgery Center of Western Ohio HIPAA Release of information

AUTHORIZATION FORM

I, _____hereby authorize Eye Surgery Center of Western Ohio LLC, and its affiliates, its employees and agents to release to

_____ **[Insert full name of person/organization]** my personal health information maintained by Eye Surgery Center of Western Ohio LLC, (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:

_____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of _____ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends on _____**.**

I understand that I have a right to revoke this authorization by providing written notice to Eye Surgery Center of Western Ohio LLC However, this authorization may not be revoked if Eye Surgery Center of Western Ohio LLC, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____

Signature of Member: _____

Date:_____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

EYE SURGERY CENTER of WESTERN OHIO
MEDICAL INFORMATION RELEASE FORM

(HIPAA Release Form)

Name:_____ Date of Birth: ___ / ___ / _____

Release of Information

( ) I authorize the release of information including the diagnosis, records: examination rendered to me and claims information. This information may be released to:

( ) Spouse _____

( ) Child(ren) _____

( ) Other _____

( ) Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ( ) my home ( ) my work ( ) my cell phone _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call.

Signed:_____ Date: ____/_____/_____