APPENDIX A
FORMS

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The Village of Waterford Fire and Rescue Department

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE OF THIS NOTICE. The Village of Waterford Fire and Rescue Department is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how we may use and disclose PHI about you.

The Department is also required to abide by the terms of the version of this Notice currently in effect. In most situations we may use this information as described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

This Notice applies to all of the records relating to your care maintained by the Village of Waterford Fire and Rescue Department. However, please note that your private doctor, and/or treating Hospital Emergency Department have separate policies and/or notices about the use and disclosure of health information that is maintained by them.

USES AND DISCLOSURES OF PHI. We may use PHI for the purposes of treatment, payment, and health care operations without your permission, as follows:

For Treatment. As we treat you, we may provide your health information to other medical personnel. For example, we provide your PHI to doctors and nurses who give orders to allow us to provide treatment to you, and to other health care personnel and the hospital to which we transfer your care and treatment.

For Payment. We may use your health information in order to get reimbursed for the services we provide to you. For example, we may submit information to our billing service, which in turn bills you, Medicare, or your insurance company. If you inform us that you will pay the bill personally and do not want it submitted to an insurer, however, we will honor that request if the bill is paid. We may also reveal PHI when necessary for the collection of outstanding bills.

For Health Care Operations. We may use your PHI to help us improve the quality of care we provide or to respond to inquiries about the care provided. For example, we may use your PHI for quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures.

OTHER USES AND DISCLOSURES OF PHI WITHOUT YOUR AUTHORIZATION. The Village of Waterford Fire and Rescue Department is permitted to use PHI *without* your written authorization or opportunity to object in certain situations, except as specifically noted below, including the following:

Family and Friends for Care and Notification. We may disclose PHI to a family member, other relative, close personal friend, or other individual identified by you that is relevant to the person's involvement in your care if we obtain your verbal agreement to do so, if we give you an opportunity to object to such a disclosure and you do not raise an objection, or we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew. We may also disclose PHI under the provisions above to notify, assist in the notification of (including identifying or locating) your family member, personal representative, or other person involved in your care of your location, general condition, or death.

Disaster Relief Purposes. We may disclose PHI to a public or private entity involved in disaster relief efforts (such as the American Red Cross) so that your family may be notified of your location, general condition, or death.

Required by Law. We may disclose your PHI when required by law to do so, to the extent required or allowed under the applicable law.

Public Health. We may disclose your PHI to a public health authority that is authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, including reporting a birth, death or disease, as part of a public health surveillance or investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law.

Reporting Victims of Abuse or Neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence if the disclosure is required or authorized by law, or if you agree to the disclosure. We will notify you or your personal representative that we have made the disclosure unless we believe that doing so would place you at risk of serious harm, or that the personal representative is responsible for the abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose your PHI for health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by law to oversee the health care system, including for health care fraud and abuse detection or for activities related to compliance with the law.

Legal Proceedings. We may disclose PHI for judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process.

Law Enforcement Purposes. We may disclose PHI for law enforcement activities in limited situations, such as when there is a subpoena for the request, when the law requires the reporting of certain types of wounds or physical injuries, or when the information is needed to locate a suspect or stop a crime.

Death. We may disclose PHI to coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law.

Serious Threats. We may disclose PHI to avert a serious threat to the health and safety of a person or the public at large.

Specialized Government Functions. We may disclose PHI for military, national defense and security and other special government functions. This also applies if you are in the lawful custody of a law enforcement officer or correctional facility.

Workers Compensation. We may disclose PHI as authorized by law to the extent necessary to comply with workers compensation laws.

De-identification. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI will only be made with your written authorization. The authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it. **You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.**

PATIENT RIGHTS. As a patient, you have a number of rights with respect to the protection of your PHI, including:

The right to access, copy or inspect your PHI. This means you may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

We have forms available for you to request access to your PHI and we will provide a written response if we deny you access and will inform you of your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer listed at the end of this Notice.

The right to amend your PHI. You have the right to ask us to amend written medical information that we may have about you. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct, or we did not create the information. If you wish to request that we amend the medical information that we have about you, you should contact the privacy officer listed at the end of this Notice.

The right to request an accounting of our use and disclosure of your PHI. You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, including when we share your health information with our business associates for any of those purposes.

We are also not required to give you an accounting of our uses of protected health information which we have given to you, incident to an authorized use or disclosure, pursuant to your written authorization, for national security or intelligence purposes, to correctional facilities or law enforcement officials as required or allowed by law, or when your right to receive the information has been suspended by law. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed at the end of this Notice.

The right to request that we restrict the uses and disclosures of your PHI.You have the right to request that we restrict how we use and disclose medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your care. We are not required to agree to a requested restriction, but if we agree to a restriction we are required to abide by it except when the information you asked us to restrict is needed to provide you with emergency treatment. In that case, we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment.

The right to request that you receive communications from us at a different place or by different means. You have the right to ask that we send you PHI by alternative means or at alternative locations if you state that the disclosure of the information could endanger you. We will accommodate reasonable requests.

The right to obtain a copy of this Notice. We will make a good faith effort to give you a copy of this Notice at the time of service, however, in an emergency situation, we will provide the notice as soon as reasonably practical. We will also attempt to get your acknowledgement that you have received the Notice, but are not required to do so in an emergency situation. We will also have the Notice available at the Waterford Fire and Rescue Department office at 122 N. Second Street, Waterford. You may always obtain a paper copy of this Notice upon request, and may request it by email. It may be posted on the Village of Waterford website.

Revisions to the Notice. The Village of Waterford Fire and Rescue Department reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and may be posted to the Village of Waterford web site. You may obtain the most current version of this Notice by contacting the Privacy Officer identified below.

Your Legal Rights and Complaints. You have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to the privacy officer listed at the end of this Notice.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Privacy Officer
Assistant Chief-EMS
Village of Waterford Fire and Rescue Department
122 North Second Street
Waterford, WI 53185
262-534-3911

Effective Date of this Notice: March 1, 2014

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that the Village of Waterford Fire and Rescue Department has given you a copy of its Notice of Privacy Practices, which explains how your protected health information will be handled in various situations.

I hereby acknowledge that I have been provided with a copy of the Village of Waterford Fire and Rescue Department's Notice of Privacy Practices on this date.

____
Date

____________________________________ Patient's Name Printed

____________________________________ Treating EMT

____________________________________ Patient's Signature

____________________________________ Parent or Legal Guardian of a Minor Patient's Signature

____
Street Address

____
City, State and Zip Code

To be completed by the Village of Waterford Fire and Rescue Department if the Acknowledgment is not signed.

1. Does patient have a copy of the Notice of Privacy Practices? ____ Yes ____No
2. Please explain why the patient was unable to sign the Acknowledgement Form and the Village of Waterford Fire and Rescue Department's efforts in trying to obtain the patient's signature:
   ____
   ____
   ____
3. ____ The Notice of Privacy Practices was sent to the patient in the mail on ________________________________

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Request for Access and Authorization for Disclosure of Protected Health Information

Patient Information:

Patient Name: ____ Date of Birth: ____________
Address: ____
Telephone ______________________ Last Four Digits of Social Security No.___________________

Authorization:

I authorize the Village of Waterford Fire and Rescue Department to release the medical information listed below to:

Name: ____
Address: ____
Telephone ______________________ Fax ________________________ Email ___________________________

Delivery Options:

Self: To be: Picked Up ____ Viewed on Site ____ Mailed to Address Above ____ Faxed ____ Emailed ____
I hereby authorize ________________________________ to pick up my records. A photo ID is required.

Other: To be: Picked Up _____ Viewed on Site _____ Mailed to Address Above ____
Faxed to Fax Number Above ____ Emailed to Email Address Above ____

Purpose of Request: ____ Further Medical Care ____ Personal (at the request of the patient)
____ Insurance Eligibility/Benefits ____ Legal Investigation (indicate whether certification is required
____ Other ____

Information to be Disclosed:
Rescue Records for dates of service beginning ________________________ and ending _________________________
Rescue Records for the following dates of service ____
Other:____

Effective Dates: This authorization is effective until ______. If no date is entered, the authorization will be valid for one year from the date of signature.

Patient Rights and Acknowledgement: I understand that I have a right to inspect and receive a copy of the protected health information that I have authorized to be used or disclosed by this authorization. I understand that I may be charged a fee for the copies in accordance with federal law. I understand that I do not have to sign this authorization in order to receive treatment. I understand that the persons or entities that I have authorized to receive a copy of my protected health information may not be subject to federal and state laws that require confidentiality, and that they may use or disclose the information. I am aware that I may revoke this authorization at any time in writing, but revocation will not be applicable to any information already used or disclosed in reliance on the authorization. A photocopy, scan, or fax of this authorization will be as effective as an original.

Signature of Patient or Legal Representative:

____ ___________________
(Signature of Patient or Legal Representative) (Date)

If signed by a person other than the patient, provide legal authority:
____ Parent of a minor child and I have not been denied periods of physical placement by a court.
____ Legal guardian of the patient (provide proof of guardianship).
____ The appointed agent under an activated Health Care Power of Attorney (provide proof and statement of incapacity).
____ Legal representative of a deceased patient (e.g., next of kin, personal representative: provide proof).

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Denial of Request for Access and/or Authorization for Disclosure of Protected Health Information

Date: ______________________________

To: ______________________________

Address: ________________________
____

We have carefully reviewed the request by ________________________ dated _________ regarding access to or disclosure of protected health information (PHI) for the following patient:

Patient Name: ____ Date of Birth: ______________

We are unable to grant all or part of this request for the reason(s) below. If we were able to grant a part of the request, that was completed on __________. The information to which the request was denied is _________________________.

1. ____ The information requested was compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding.
2. ____ The information requested 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.
3. ____ The information requested may not be released to you under the following law ____________________.

Denial for reasons 1, 2 or 3 are final and may not be appealed.

4. ____ A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
5. ____ The protected health information makes reference to another person (other than a health care provider) and a licensed health professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to that person.
6. ____ The request for access is made by you as a personal representative of the individual about whom you are requesting the information, and a licensed health professional has determined, in the exercise of professional judgment, that access by you is reasonably likely to cause harm to the individual or another person.

If the denial of the request for access to or disclosure of PHI is for reasons 4, 5 or 6, you may request a review of the denial by sending a written request to:

Privacy Officer, Assistant Chief-EMS
Village of Waterford Fire and Rescue Department
122 North Second Street
Waterford, WI 53185

We will designate a licensed health professional who was not directly involved in the denial to review the decision to deny access. We will promptly refer your request to this designated review official. The review official will determine within a reasonable period of time whether the denial is appropriate. We will provide you with written notice of the determination of the designated review official.

You may also file a complaint in accordance with our complaint procedures (available upon request) if you are not satisfied with our determination.

Sincerely,

____
Privacy Officer
Village of Waterford Fire and Rescue Department

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Request for Amendment of Protected Health Information

Patient Name: ____
Address: ____
City: ____ State: ________ Zip Code:_____
Date of Birth: ___________________________

Information to Amend:
Please check the field that represents the type of information you would like to amend.

____ Name	____ Marital Status
____ Billing Address	____ Surrogate Decision Maker
____ Mailing Address	____ Organ Donor
____ Current Medical Condition	____ Other: Please describe
____ Past Medical History	_________________________________
____ Current Medications	_________________________________
____ Allergies	_________________________________

Amended Information: ____
____
____
____

Reason for Amendment:____
____
____

Please specifically describe what information you want amended, and the reason for the amendment. Please ONLY list the new information. Attach a separate sheet if necessary.

The Village of Waterford Fire and Rescue Department, in its capacity as a health care provider, is entitled to perform and bill for services based on all protected health information in its current form or upon which it has already relied until such time as the amended information becomes effective. We are not required to accept your request for amendment and will notify you in writing as to the decision regarding your request.

Your signature below indicates that you have been informed of these terms and to provide payment, if required, to the Village of Waterford Fire and Rescue Department based on existing protected information until such time that the amendments you have made are effective.

Signature of Patient or Legal Representative:

____ ___________________
(Signature of Patient or Legal Representative) (Date)
If signed by a person other than the patient, provide legal authority:
____ Parent of a minor child and I have not been denied periods of physical placement by a court.
____ Legal guardian of the patient (provide proof of guardianship).
____ The appointed agent under an activated Health Care Power of Attorney (provide proof and statement of incapacity).
____ Legal representative of a deceased patient (e.g., next of kin, personal representative: provide proof).

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Denial of Request for Amendment to Protected Health Information

Date: ________________________________

To: ________________________________

Address: __________________________
____

We have carefully reviewed the request by ___________________________ dated _________ for the amendment of the protected health information (PHI) for the following patient:

Patient Name: ____ Date of Birth: ______________

Please be advised that we must deny your request to amend this information at this time for the following reason(s):

____ This Fire/Rescue Department did not create the information.
____ The original information is located at:____
____ We do not know the location of the original information.
____ The information is not part of the Designated Record Set.
____ The information would not be available under state or federal law.
____ The information is accurate and complete.
____ Other: ____

If you disagree with this denial, you may file a written statement of disagreement with the Village of Waterford Fire and Rescue Department. You may file your statement directly with the Privacy Officer at the address listed above If you choose not to file a statement of disagreement, you may request that we include your Request for Amendment of Health Information and a copy of this denial of your request, with any future disclosures of the protected health information (PHI) that was the subject of your request for amendment.

You also have the right to file a complaint with us or with the federal government if you disagree with our decision to deny your request to amend your PHI. You may file a complaint with the Privacy Officer at the following address:

Privacy Officer, Assistant Chief-EMS
Waterford Fire and Rescue Department
122 N. Second St.
Waterford, WI 53185
262-534-3911

Sincerely,

____
Privacy Officer
Village of Waterford Fire and Rescue Department

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Response to Statement of Disagreement with Denial of Request for Amendment of Protected Health Information

Date: ______________________________

To: ______________________________

Address: ________________________
____

We have carefully reviewed the request by _________________________ dated _________ for the amendment of the protected health information (PHI) for the following patient:

Patient Name: ____ Date of Birth: ______________

Please be advised that we have received your "Statement of Disagreement" in response to our letter notifying you of our denial of your Request for Amendment of Protected health Information. Your initial request, our letter of denial and your statement of disagreement has been reviewed with the management of the Village of Waterford Fire and Rescue Department and the Medical Director.

After considering your initial request, our denial of the request and your statement of disagreement the following was determined:

____ The initial Request for Amendment of Protected Health Information will be honored and the requested amendment will be made. Please see the attached Acceptance of Request for Amendment of Protected Health Information for additional information.

____ Your request continues to be denied. Your request for amendment, our denial of the request, your statement of disagreement and our 2nd denial letter will be added to the Designated Record Set for the patient listed above.

Sincerely,

____
Privacy Officer
Village of Waterford Fire and Rescue Department

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Acceptance of Request for Amendment of Protected Health Information

Date: ______________________________

To: ______________________________

Address: ________________________
____

We have carefully reviewed the request by _________________________ dated _________ for the amendment of the protected health information (PHI) for the following patient:

Patient Name: ____ Date of Birth: ______________

Please be advised that we have made the appropriate amendment to the PHI or record that was the subject of your request.

We are now requesting that you grant us permission to allow us to notify the persons with which the amendments need to be shared. We will provide the amended PHI to those individuals you identify to us as having received the PHI as well as those persons or business associates that have such information and who may have relied on or could be reasonably expected to rely on the amended PHI.

Please identify to us any individuals you know of who may need the amended PHI about you and sign the statement below giving us permission to provide them with the updated PHI. If you have any questions, please contact

Privacy Officer, Assistant Chief-EMS
Village of Waterford Fire and Rescue Department
122 North Second Street
Waterford, WI 53185
(262) 534-3911

Sincerely,

____
Privacy Officer
Village of Waterford Fire and Rescue Department

By my signature below, I hereby authorize the Village of Waterford Fire and Rescue Department to provide amended PHI that it may have about ____________________ to the following persons, and to others whom the Department has identified that have a need for such information, provided such information is furnished in accordance with federal law.

Contact information for persons I know need the amended PHI:

____
____
____
____

Signature of Patient or Legal Representative:

____ ________________
(Signature of Patient or Legal Representative) (Date)
If signed by a person other than the patient, provide legal authority:
____ Parent of a minor child and I have not been denied periods of physical placement by a court.
____ Legal guardian of the patient (provide proof of guardianship).
____ The appointed agent under an activated Health Care Power of Attorney (provide proof and statement of incapacity).
____ Legal representative of a deceased patient (e.g., next of kin, personal representative: provide proof).

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Request for Restriction of Protected Health Information

Patient Name: ____
Address: ____
City: ____ State: ________ Zip Code:_____
Date of Birth: ___________________________

An individual has the right to request the restriction of uses and disclosures of protected health information to carry out treatment, payment or health care operations; for the disclosure of PHI for the purpose of involvement in the person's care (e.g. to family members, relatives, close friends); and for notification purposes or disaster relief purposes. We are not required to agree to the above restrictions, except when a patient agrees to pay directly for services, we may not bill the insurer. If we agree to the restriction, we are bound by that agreement. An individual may terminate the restriction in writing. If an individual terminates the restriction orally, we will document that termination. In addition, we must agree to accommodate reasonable requests for communications by alternative means or at alternative locations.

Restriction(s) Requested:

____
____
____
____
____
____

Termination of Restriction Requested:

____

Signature of Patient or Legal Representative:

____ ____________________
(Signature of Patient or Legal Representative) (Date)

If signed by a person other than the patient, provide legal authority:

____ Parent of a minor child and I have not been denied periods of physical placement by a court.
____ Legal guardian of the patient (provide proof of guardianship).
____ The appointed agent under an activated Health Care Power of Attorney (provide proof and statement of incapacity).
____ Legal representative of a deceased patient (e.g., next of kin, personal representative: provide proof).

____

FOR DEPARTMENT USE ONLY

DATE REC'D _____________________ REQUEST ACCEPTED ________ REQUEST DENIED _________
DATE _________________________________
REVIEWING OFFICIAL ______________________________ NOTICE TO PT SENT ON ______________________
COMMENTS: ____
____
____

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Thirty Day Extension

Date: ________________________________

To: ________________________________

Address: __________________________
____

We have carefully reviewed the request by ___________________________ dated _________ regarding ____
for the following patient:

Patient Name: ____ Date of Birth: ______________

Federal law requires that we respond to your request within 30 days (60 days in some instances). Federal law also allows us to extend this time period for an additional 30 days. At this time, we are notifying you of the need for a thirty day extension in processing your request. This extension is necessary for the following reason:

____ The information that you requested is not maintained or accessible to us on site, and we are working to obtain the information in order to fulfill your request.

____ Other: ____

We will fulfill the request or explain why we cannot fulfill the request by __________________.

Sincerely,

____
Privacy Officer
Village of Waterford Fire and Rescue Department

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Accounting Log for Disclosures of Protected Health Information

Patient Name: ____
Date of Birth: ____

Pursuant to 45 CFR 164.528, the Village of Waterford Fire and Rescue Department is required to account for the disclosure of protected health information of an individual except for disclosures:

1. To carry out treatment, payment and health care operations per s. 164.506.
2. To individuals of PHI information about them per s. 164.502.
3. Incident to a permitted disclosure per s. 164.502.
4. Pursuant to an authorization per s. 164.508.
5. For national security or intelligence purposes per s. 164.512(k)(2).
6. To correctional institutions or law enforcement officials per s. 164.512(k)(5).
7. As part of a limited data set per s. 164.514(e).

Any disclosure for a purpose other than the above must be documented, and the disclosure must be kept in the patient's Designated Record Set.

The following disclosures were made for the patient listed above:

Date disclosed: ______________________

Requestor Name/Company/Title: ____

Address of Requestor: ____

Information Disclosed: ____

____

Purpose of Disclosure: ____

Authorized by Patient/Date ____

Privacy Officer Signature ____

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Patient Accounting Request and Response Form

Patient Name: ____
Address: ____
City: ____ State: ________ Zip Code: ____________
Date of Birth: ____________________________

An individual has the right to request an accounting of certain uses and disclosures of protected health information (PHI) for the six years prior to the date of the request. The Village of Waterford Fire and Rescue Department is not required to provide an accounting of uses and disclosures associated with treatment and transport, or for billing, payment or health care operations, and for several other reasons as set forth in 45 CRF 164.528. I hereby request an accounting of the disclosure(s) of PHI for the above patient for the services rendered on the following dates: __________________________
____

Signature of Patient or Legal Representative:

____ ____________________
(Signature of Patient or Legal Representative) (Date)

If signed by a person other than the patient, provide legal authority:

____ Parent of a minor child and I have not been denied periods of physical placement by a court.
____ Legal guardian of the patient (provide proof of guardianship).
____ The appointed agent under an activated Health Care Power of Attorney (provide proof and statement of incapacity).
____ Legal representative of a deceased patient (e.g., next of kin, personal representative: provide proof).

List of Uses and Disclosures

Date disclosed: ______________________

Requestor Name/Company/Title: ____

Address of Requestor: ____

Information Disclosed: ____

____

Purpose of Disclosure: ____

Authorized by Patient/Date ____

Privacy Officer Signature ____

The Village of Waterford Fire and Rescue Department
122 N. Second St., Waterford, WI 53185

Log for Processing Complaints About Privacy Practices

Pursuant to 45 CFR 164.530, the Village of Waterford Fire and Rescue Department is required to document all complaints, and their disposition, if any.

Date Complaint Received: ________________________

Patient Name: ____
Address: ____
City: ____ State: ________ Zip Code: ____________
Date of Birth: ____________________________

Description of Complaint: ____
____

Disposition of Complaint: ____
____

Privacy Officer: __________________________________
Village of Waterford Fire and Rescue Department