Community Health Group	POLICY TYPE: ☒Corporate ☐ Divisional			
EFFECTIVE DATE: April 2014	INITIAL APPROVAL DATE: April 2014	NEXT REVIEW DATE: May 2017	POLICY NUMBER: 5505	
REVISION APPROVAL DATE: 11/14, 3/15, 1/16		APPLIES TO PRODUCT TYPE: ☒Medi-Cal ☒ CMC		PAGE: 1 of 34
POLICY APPLIES TO: All Divisions and Departments		CLASSIFICATION SERIES: Compliance		
SUBJECT: Policy on Individual Rights				

Purpose/Statement:

The purpose of this policy is to outline the procedures of Community Health Group and Community Health Group Partnership Plan (collectively, "CHG") for providing individuals with the right to access, amend, receive an accounting of, and restrict Uses and Disclosures of their Protected Health Information ("PHI"), as required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164 ("HIPAA").

1.0 POLICY

1.1. CHG shall provide individuals whose PHI CHG maintains with the right to access, amend, receive an accounting of and restrict Uses and Disclosures of their PHI in accordance with HIPAA. CHG shall provide such individuals with a timely response to their requests relating to their PHI under this Policy. In addition, CHG will have a designated contact person for individuals to direct any questions or concerns on CHG's Use or Disclosure of their PHI.

2.0 AREAS INVOLVED

2.1. All Departments

3.0 KEY DEFINITIONS

The following are definitions of key terms used in this Policy. The definitions of other capitalized terms used in this policy and not defined in this Section 3.0 can be found in the Glossary.

3.1. **"Access"** means an individual's right to inspect and obtain a copy of their PHI contained in a Designated Record Set maintained by CHG.

3.2. **"Disclose"** and **"Disclosure"** means, with respect to PHI, the release of, transfer of, provision of access to, or divulging in any manner, of PHI outside of CHG's internal operations or to other than its Workforce Members.

3.3. **"Designated Record Set"** means a group of records maintained by or for a Covered Entity that is: (i) The medical records and billing records about individuals maintained by or for a covered Health Care Provider; (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a Health Plan; or (iii) Used, in whole or in part, by or for the Covered Entity to make decisions about individuals.

3.4. **"Protected Health Information"** ("PHI") means information that (i) is created or received by a Health Care Provider, Health Plan, employer or Health Care Clearinghouse; (ii) 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 (iii) identifies the individual (or for which there is a reasonable basis for believing that the information can be used to identify the individual).

3.5. **"Use"** or **"Uses"** means, with respect to PHI, the sharing, employment, application, utilization, examination or analysis of such information within CHG's internal operations.

4.0 PROCEDURE

4.1. ACCESS RIGHTS

4.1.1. CHG shall provide individuals the right to access their PHI.

EXCEPTIONS: Individuals do not have a right of access to:

4.1.1.1 PHI compiled for use in a civil, criminal or administrative proceeding; and

4.1.2. An individual must complete a written request form in order to access his or her PHI using the Form to Request Access. Member Services shall be responsible for providing individuals an explanation of their access rights and shall be responsible for receiving, processing and documenting individuals' access requests.

4.1.3. PROVIDING ACCESS

4.1.3.1 Member Services shall allow individuals to come to the facility to view their PHI (in accordance with Section 4.1.5) within 5 working days of receiving an individual's Access request and payment of reasonable clerical costs. If the individual does not want to pay such costs, then CHG will allow them to view their PHI in accordance with Section 4.1.5 within 30 days after receiving the Access request.

4.1.3.2 If the individual requests a summary of PHI, Member Services must act on the individual's access request within 10 working days. If Member Services is unable to act on the access request within the initial 10 days either because of the length of the record or because the individual was discharged from the hospital within the prior 10 days, it may extend the period by no more than 30 days, provided that the individual is provided with a written statement of the reasons for the delay and the date by which CHG will provide a response to the individual's access request. Member Services may have only one extension of time to act on an individual's access request.

4.1.3.3 If the individual is requesting to receive copies of his or her PHI, Member Services shall send such copies within 15 days after receiving the individual's Access request and after receiving payment of copy fees.

4.1.4. At no time shall an individual be permitted to review his or her PHI on-site without direct supervision by a Workforce Member. Only treating Health Care Providers can give the individual an interpretation of the meaning of an entry or the care provided. Workforce Members must refer the individual to discuss such questions with his or her attending physician. Under no circumstances, should originals of the individual's PHI leave the premises.

4.1.5. Member Services may deny an individual's request for access, and not provide that individual with the opportunity to request CHG to review the decision in the following circumstances:

4.1.5.1 PHI compiled for use in a civil, criminal or administrative proceeding;

4.1.5.2 The individual has agreed to the denial of access when consenting to participate in research and CHG informs the individual that the right of Access will be reinstated upon completion of the research;

4.1.5.3 As the Privacy Act, 5 U.S.C. § 552a so requires; or

4.1.5.4 CHG is not the source of the information, and it received such information under the promise of confidentiality, and access would be likely to reveal the confidential source.

4.1.6. Member Services may deny an individual's request for access, within 5 working days of receiving the request, under the following circumstances, but must provide the individual with the opportunity for a review of the decision in accordance with Section 4.1.7 below:

4.1.6.1 A licensed health care professional determines that access is reasonably likely to endanger the individual or another person's life or physical safety;

4.1.6.2 The PHI makes reference to another person who is not a health care provider and a licensed health care professional has determined that Access is likely to cause substantial harm to such other person; or

4.1.6.3 The request is made by the individual's personal representative and a licensed health care professional has determined that provision of access to the personal representative is likely to cause substantial harm to the individual or another person.

4.1.6.4 The attending physician or licensed health care professional shall make the determination as to whether access should be permitted as follows:

a) If the individual is an inpatient, the approval of access by the attending physician shall be obtained. If approved, the physician shall write an order that the individual may have access to their PHI and shall forward a copy of that order to Member Services. If not approved, the physician shall complete, sign, and date an entry in the individual's progress notes regarding the reason for disapproval, including a statement that it is not in the individual's best interest to have access. The attending physician shall also complete a Denial of Access Form and provide a copy of the Form to the individual and to Member Services.

b) In all other settings, the appropriate health care professional will make the access determination and document the decision in the individual's progress notes. In addition, if the health care professional approves the request for access, he or she shall write an order indicating such approval and forward a copy of the order to Member Services. If the health care professional denies a request for Access, he or she shall complete a Denial of Access Form and provide a copy of the Form to Member Services who is responsible for forwarding the form to the individual.

4.1.6.5 Individuals have a right to have a denial of access reviewed by a licensed health care professional designated by CHG who did not participate in the original decision to deny the access request (the "Official"). Individuals that wish to request a review shall complete the Form to Request Review of a Denial of Access. All such Forms shall be forwarded to Member Services. Member Services shall forward the request to the Official within 2 days of receipt. The Official will review the denial within a reasonable time period based on the criteria set forth in Section 4.1.6.4 above. The Official shall provide his or her decision in written form to Member Services. CHG is bound by the Official's decision. Member Services will provide the individual with written notice of the Official's decision on review within 2 days of receipt. Member Services shall take steps to implement the Official's decision as provided in this policy.

4.1.7. If CHG <u>denies access</u>, it shall: 1) make other information accessible to the individual that was not included in the denial; 2) provide a timely written explanation for the denial that states a) the basis for denial, b) the individual's review rights and how the individual may obtain such review rights, and c) the process for complaining to CHG or the Secretary of the Department of Health and Human Services **(See Denial of Access Form)**; and 3) if CHG does not maintain the PHI requested and it knows

the third party who does maintain such information, organization must inform the individual as to who maintains such information.

4.1.8. If CHG grants access: it will provide PHI in the form the individual requested, including allowing the individual to inspect the PHI, providing the individual with a hard copy or both. In the event that the individual requests that the PHI be provided in some other form or format, Member Services shall comply with such request, if the PHI is readily producible in such form or format. Member Services will take steps to reasonably ensure that it provides Access within the time frames set forth in this policy.

4.1.8.1 In the event that a dispute arises between Member Services and the individual as to the scope, format, form or other aspects of the Access, Member Services shall consult with the Compliance Officer to resolve such disputes.

4.1.8.2 If the PHI is kept in multiple Designated Record Sets or at more than one location, CHG will only provide the PHI once in response to a request for access. It is Member Services' responsibility to identify all applicable PHI from all locations within CHG, including any applicable PHI that is maintained by a Business Associate. Member Services shall determine and implement the most efficient method of gathering the PHI to be provided to the individual pursuant to a grant of Access.

4.1.8.3 CHG's response can be in summary form, if the individual agrees in advance to such response and to the corresponding fees. CHG will impose a reasonable, cost-based fee in accordance with California law. The individual will pay for such response by check or money order made out to Organization.

4.1.9. CHG will charge a reasonable lot-based fee, which shall consist of labor for copying; supplies for creating the paper copy or electronic media if the individual requests that an electronic copy be provided on portable media; and postage. CHG shall charge 25 cents per page and 50 cents per page for copies from microfilm, as permitted by California law. Copies will be sent to the individual within 15 days after CHG receives a written request with payments of fees and costs.

4.1.10. SPECIAL ACCESS RULES FOR PSYCHOTHERAPY NOTES, MENTAL HEALTH RECORDS AND RECORDS OF INMATES

4.1.10.1 CHG should consult legal counsel for assistance with regard to access requests for psychotherapy notes and mental health records and for records of inmates.

4.1.11. Department of Health Care Services ("DHCS") Access to PHI

4.1.11.1 CHG shall provide DHCS with access to PHI in a member's Designated Record Set in the time and manner designated by DHCS, upon reasonable notice and during CHG's normal hours.

4.1.11.2 CHG shall use the forms and processes developed by DHCS for this purpose.

4.1.11.3 CHG shall respond to DHCS' request for access to records within 15 calendar days of receipt of the request by either producing the records, or verifying that there are no records.

4.2. AMENDMENT RIGHTS

4.2.1. Individuals have the right to request amendment of their PHI maintained by CHG in a Designated Record Set. The requirements contained in this Section 4.2 only apply to PHI contained in a Designated Record Set for as long as the PHI is maintained in such Designated Record Set.

4.2.2. Individuals who wish to request an amendment of their PHI must submit such request in writing by completing the attached Form to Request Correction/Amendment. All such Forms will be forwarded to Member Services for processing. Such requests must include the reason for the amendment. If CHG is informed by another Covered Entity of an amendment to an individual's PHI, Member Services is responsible for amending the individual's PHI in accordance with this policy.

4.2.2.1 Member Services shall notify the attending physician that his or her patient has made a request for an amendment.

4.2.3. Member Services must act within 60 days of receipt of an amendment request. If Member Services is unable to provide an answer to the individual's amendment request within the initial 60 day period, it may extend the period by no more than 30 days; provided that, Member Services, within the initial 60 days, provides the individual with a written statement of the reasons for the delay and the date by which Member Services will provide an answer to the amendment request. Member Services may have only one extension of time to provide individuals with an answer to their amendment requests.

4.2.4. A request for an amendment can be <u>denied</u> if:

4.2.4.1 The PHI was not created by CHG, unless the individual provides a reasonable basis to support the belief that the originator of the PHI is no longer available to act on the requested amendment;

4.2.4.2 The PHI that is the subject of the requested amendment is not part of the Designated Record Set;

4.2.4.3 The PHI is not available for inspection pursuant to Section 4.1 (Access rights); or

4.2.4.4 The PHI or record that is the subject of the requested amendment is accurate and complete.

4.2.5. Member Services shall consult with the individual's attending physician, or other health care professional, as necessary to determine if a request for amendment should be denied.

4.2.6. If Member Services determines that it must deny the requested amendment, in whole or part, it must:

4.2.6.1 Provide a timely, written notice of the denial using the Denial of Correction/Amendment Form which shall inform the individual of 1) the basis for the denial, 2) information on how the individual can file a written statement disagreeing with the denial and where it should be filed, 3) statement that if the individual does not submit a statement of disagreement, the individual may request that CHG include the individual's request for amendment and CHG's denial of such with any future Disclosures that CHG makes of PHI that is the subject of the amendment, and 4) how the individual may complain to Organization or the Secretary of the Department of Health and Human Services.

4.2.6.2 Member Services shall also inform the individual of his or her right to submit a written statement disagreeing with CHG's denial of an amendment; however, Member Services may reasonably limit the length of such statement.

4.2.6.3 Member Services may prepare a written rebuttal to an individual's written statement of disagreement. If Member Services prepares a rebuttal, it must take steps to provide the individual a copy of the rebuttal.

4.2.6.4 Recordkeeping: Member Services will identify the PHI in the Designated Record Set that is the subject of the disputed amendment and append or otherwise link 1) the individual's request for amendment, 2) CHG's denial for request, 3) the individual's statement of disagreement (if the individual submitted a statement), and 3) CHG's rebuttal, if any.

4.2.6.5 Future Disclosures: The information required under Section 4.2.6.4 above will also be included with any future disclosure(s) of the individual's PHI, upon the individual's request. If the individual filed a statement of disagreement, such information will be included with any future disclosure(s) regardless of whether the individual requested it to be included. In the event that a future disclosure is made using a Standard Transaction, as defined in 45 CFR Part 162, that does not permit the information required under Section 4.2.6.4 to be included, Member Services shall submit such information separately.

4.2.6.6 Addendum Rights. Member Services must allow an adult individual to send a written addendum to be added to his or her PHI, following his or her inspection of the PHI.

4.2.6.6.1 The addendum must be limited to 250 words for each item that the individual believes is incomplete or incorrect.

4.2.6.6.2 The individual must clearly indicate that he or she wants the addendum to be included in his or her PHI.

4.2.6.6.3 Member Services does not have a right to deny such requested addendum.

a) The written addendum properly submitted must be included in the individual's PHI within 30 days after receipt.

4.2.7. In the event that Member Services determines that it must accept the requested Amendment in whole or in part, it must:

4.2.7.1 Make the appropriate amendment to the affected PHI or record. To do so appropriately, Member Services shall, at a minimum, identify the records or information in the Designated Record Set that are affected by the amendment and append or otherwise provide a link to the location of the amendment;

4.2.7.2 Inform the individual in a timely manner and in accordance with Section 4.2.3 above, that CHG accepts the amendment. Member Services must obtain the individual's agreement that CHG can share the amendment with relevant third parties; and

4.2.7.3 Make reasonable efforts to inform others of the amendment using the Form Notice to Third Parties of Correction/Amendment, including Business Associates, that may have had access to the PHI and could have foreseeably relied on it, and other persons or entities identified by the individual.

4.3. ACCOUNTING RIGHTS

4.3.1. An individual has a right to an accounting of certain of CHG's (and its Business Associates') disclosures of the individual's PHI made in the past six years (or a shorter period, upon the individual's request). Individuals shall make requests for an accounting by completing and submitting to Member Services the Form to Request Accounting. Member Services shall be responsible for receiving, processing and documenting such requests. Member Services shall refer to the Disclosure Log for Accounting for the information that must be included in the written accounting to the individual.

4.3.2. Upon an individual's request, and subject to the exceptions set forth below, Member Services must provide an individual with a written accounting by completing the Form for Accounting Disclosures within 60 days of such individual's request. If Member Services is unable to provide an accounting within the initial 60 day period, it may extend the period by no more than 30 days; provided that Member Services, within the initial 60 days, provides the individual with a written statement of the reasons for the delay and the date by which Member Services will provide an accounting. Member Services may have only one extension of time to provide the individual with an accounting.

4.3.3. Individuals do not have the right to receive an accounting of the following types of disclosures:

a) Disclosures to carry out Treatment, Payment or Heath Care Operations;

b) to the individual themselves;

c) an Incidental Use or Disclosure;

d) a disclosure made under an Authorization;

e) for a facility directory;

f) to persons involved in the individual's care or other notification purposes;

g) for national security or intelligence purposes;

h) to correctional institutions or law enforcement officials in custodial situations;

i) as part of a Limited Data Set;

j) for disclosures of PHI that occurred prior to the compliance date of HIPAA.

4.3.3.1 Member Services is responsible for suspending an individual's right to receive an accounting if a Health Oversight Agency or a law enforcement official provides a written statement that such accounting would be reasonably likely to impede their activities. The written statement must also specify the amount of time for which such a suspension of rights is required. If a Health Oversight Agency or law enforcement official provides such request orally, Member Services must, 1) document the statement and the identity of the agency or official making the request; 2) temporarily suspend the individual's right to accounting; and 3) limit the suspension to 30 days, unless a written statement is submitted during that time period.

4.3.4. Member Services will make accountings on Form for Accounting Disclosures, which includes the following information:

4.3.4.1 If Section 4.3.4.2 below is not applicable, then the accounting must include: 1) the date of Disclosure(s); 2) name of the entity or person who received the PHI and, if known, the address of such person or entity; 3) a brief description of the PHI Disclosed; and 4) the purpose for Disclosure, or in lieu, a copy of the individual's written request for Disclosure or a copy of a request for Disclosure for which Authorization or an Opportunity to Agree or Object was not required.

4.3.4.2 If Member Services made multiple Disclosures of PHI to one entity or person for a single purpose pursuant to a request from the individual or a request for which Authorization or Opportunity to Agree or Object was not required, Member Services may provide the individual with all of the information listed in 4.3.4.1 for the first Disclosure during the accounting period and the frequency, periodicity, or number of Disclosures made during the accounting period and the date of the last such Disclosure during the accounting period.

4.3.5. Fees: The first accounting to an individual in a 12-month period shall be free of charge. Thereafter, Member Services will calculate and impose a cost-based fee for each subsequent request for an accounting within that 12-month period; provided that Member Services informs the individual (before payment of the fee) that the individual has the opportunity to withdraw or modify his or her request in writing in order to avoid or reduce the fee. The individual shall pay for the accounting by check or money order made out to CHG.

4.4. RESTRICTION RIGHTS

4.4.1. CHG will permit individuals to request CHG to restrict uses and disclosures of their PHI for Treatment, Payment and Health Care Operations purposes, and Disclosures to those involved in the individual's care or Payment for such individual's care and for notification purposes. Individuals must make requests for a restriction by completing the Form to Request Restriction. All such Forms will be forwarded to Member Services for review. CHG, however, is not required to agree to the individual's request for restriction, except for restrictions covered by 45 C.F.R. § 164.522(a) (pertaining to disclosures to a health plan for the purpose of carrying out payment or health care operations) and the restriction applies to PHI that pertains solely to a health care item or service which the member paid for out of pocket.

4.4.2. Member Services shall review all restriction requests and determine whether CHG can reasonably accommodate the request.

4.4.3. If Member Services agrees to such request, Member Services must document the request using the Documentation of Granted Restriction

Form and take reasonable steps to help ensure that CHG abides by the restriction.

4.4.3.1 CHG is not required to abide by the agreed to restriction if the individual who requested the restriction is in need of emergency treatment. If such a situation exists, CHG can release the individual's PHI to a Health Care Provider; provided that CHG requests that the Health Care Provider not further disclose the individual's PHI.

4.4.3.2 CHG is not required to implement the restriction for Uses and Disclosures to the Secretary of the Department of Health and Human Services to investigate or determine CHG's compliance with HIPAA, for facility directories and Uses and Disclosures for which Authorization, or Opportunity to Agree or Object is not required.

4.4.4. In the event that Member Services determines that CHG should terminate its agreement to a restriction, it may do so in the following ways:

4.4.4.1 If the individual agrees to the termination in writing;

4.4.4.2 If the individual orally agrees to the termination and the oral agreement is documented; or

4.4.4.3 If Organization informs the individual it is terminating its agreement to the restriction (such termination is only effective with respect to the PHI created or received after CHG informed the individual).

4.4.5. Member Services shall provide the individual with a Revocation of Agreement to Requested Restriction Form and shall document the termination of such agreement.

5.0 **DOCUMENT RETENTION**

5.1. All documents required to be created or completed under this policy shall be maintained as is specified in this policy or shall be maintained in the Operations Department.

6.0 **CONTACT FOR QUESTIONS**

6.1. If a Workforce Member has any questions or is uncertain about the requirements described in this policy, such Workforce Member shall contact Compliance Officer or the designated Chief.

Access Privileges: ☒ All ☐ _____

Regulatory: 45 C.F.R. §§ 164.522, 164.524, 164.526, 164.528. Cal. Health & Safety Code §§ 56.101, 56.07. California General Managed Care Template, Exhibit G.

NCQA:

Attachments:

Policy Status: ☒ Signed (Signature on File) ☐ Active Draft ☐ Policy in Development

Approved By:

Signature: _____

Department Head: Chief Compliance & Regulatory Affairs Officer
Date: _____

Signature: _____

Division Chief: Chief Executive Officer

Date: _____

FORM 1

REQUEST FOR ACCESS TO HEALTH INFORMATION IN A DESIGNATED RECORD SET HELD BY COMMUNITY HEALTH GROUP

1. Name of requesting individual:

_____

2. Date of request:

_____

3. Indicate below the method of access to your health information that you are requesting:

_____ Inspection of the health information
_____ A copy of the health information
_____ Both inspection and a copy of the health information
_____ A summary of the health information prepared by CHG instead of access to all of the health information

4. Indicate below the format of access that you are requesting:

_____ Paper copy of the health information
_____ Other. Please describe: _____

_____

Information about your access rights

Except under limited circumstances, we will provide you with the access you request. We will respond to your request for access within 5 days of receiving this completed form and payment of our reasonable clerical costs. If you do not wish to pay the fee for expedited service, we will let you know when and where you can see your PHI within 30 days of receiving this completed form. If we do not have your PHI readily accessible, we will let you know when and where you can see it within 60 days of receiving this completed form. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed.

Charges for Access

If you ask us to copy your health information, we will charge you $0.25 per page (or $.50 if copied from microfilm). If you request copies of x-rays or tracings of EKG, ECG, or electromyography, we will charge you the actual costs of duplication. Copies will be sent to you within 15 days after we receive written request with payment of fees and costs. Alternatively, we may provide you with a summary or explanation of your health information, as long as you agree to that, and to the cost, in advance. If you indicate above that you would like a summary of your health information, we will inform you of the cost for that summary prior to providing you with the summary. If you do not agree to the charge, we will not prepare the summary.

Where to Submit this Form

You must submit this form to the Director of Customer Experience at:

Community Health Group
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

By submitting this form, I hereby request CHG to provide me with access to my health information that CHG maintains.

Name:_____
Signature:_____
Date:_____

Name of Workforce Member who received this form: _____

Date form received: _____

FORM 2

DENIAL OF A REQUEST FOR ACCESS
BY COMMUNITY HEALTH GROUP

Dear _____:

CHG has reviewed your request for access to your health information and has determined that it must deny your request **[insert whether denial is in whole or in part].** The following is information as to the basis for our denial and your rights regarding the denial.

1. **[Applicable if the denial is only in part]** Description of the information to which CHG is denying your request for access:

   _____

   _____

2. Basis for the denial:

   _____

   _____

3. **[Applicable if the basis for denial is such that the individual has the right to request a review (see policy on Individuals' Rights)]** You have the right to request a review of our decision to deny your request for access. To request a review, you must complete the Form to Request Review of a Denial of Access, which is attached to this document. You must submit the completed form to Chief of Regulatory and Legal Affairs/Compliance Officer at:

   Community Health Group
   2420 Fenton Street, Suite 100
   Chula Vista, CA 91914

   The review will be conducted by a licensed health care professional, designated by CHG, who did not participate in CHG's decision to deny your request for access. The licensed health care professional will review the denial and make a written decision within 30 days of receipt of the request for review. CHG is bound by the licensed health care professional's decision. We will provide you with written notice of the decision on review.

4. You have the right to submit a complaint to CHG by contacting the Grievance and Appeals Manager at:

   Community Health Group
   Attention: Grievance and Appeals Manager
   2420 Fenton Street, Suite 100
   Chula Vista, CA 91914
   (619) 498-6578 (Phone)

   You also have a right to submit a complaint about CHG to the Secretary of the Department of Health and Human Services ("Secretary"). If you wish to submit a

complaint to the Secretary about CHG's decision to deny your request for access, you must file it in writing, either on paper or electronically. The complaint must name CHG and describe how you believe CHG violated your right to have access to your health information. You must file the complaint within 180 days of the time CHG denied your request for access.

5. **[Applicable if the denial was based on the fact that CHG does not maintain the health information requested, but knows the third party who does maintain such information.]** Although CHG has denied your request for access because we do not maintain the information you requested, we believe the information is held by (the applicable party) and you should direct your request for access to that entity or person.
6. If you have any questions, please contact the Member Services Department at 1-800-224-7766.

FORM 3

REQUEST FOR REVIEW OF DENIAL OF ACCESS BY COMMUNITY HEALTH GROUP

1. Name of requesting individual:

_____

_____

2. Date of request:

_____

3. Reason for the review request:

_____

_____

_____

4. Please attach the form you submitted to CHG to request access, and a copy of the denial that CHG provided to you.

Where to Submit this Form

You must submit this form to the Chief of Regulatory and Legal Affairs/Compliance Officer at:

Community Health Group
Attention: Chief of Regulatory and Legal Affairs/Compliance Officer
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

By submitting this form, I hereby request CHG to provide me with a review of CHG's decision to deny me access to my health information that CHG maintains.

Name:_____

Signature:_____

Date:_____

Name of Workforce Member who received this form: _____

Date form received: _____

FORM 4

REQUEST FOR PROTECTED HEALTH INFORMATION (PHI) AMENDMENT

IDENTIFICATION – (Please Print)

Identification of Member/Participant: (The following information is needed for verification. Please complete all applicable items.)

Name of Member: _____ Date of Birth: _____
Phone number where we can reach you, if we need to contact you to process your request (required):
_____
Plan you enrolled in: ____ Cal MediConnect ____ Medi-Cal

Member ID card number (if applicable):_____

Subscriber Name (if different from Member): _____

Subscriber's Relationship to Member (if applicable):_____

Subscriber's Employer Name (if applicable): _____

REQUESTED AMENDMENT

Please describe the amendment you are requesting as thoroughly as possible (attach more sheets as needed), including the reason for the change:
_____
_____
_____
_____
_____
_____
_____

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION
This form will allow me, as a Community Health Group member, to request an amendment of my protected health information that is maintained by Community Health Group. I understand Community Health Group will consider all requests for amendment carefully; however Community Health Group is not necessarily required to agree to a requested amendment.

1. Name of requesting individual:
_____

2. Date of request:
_____

3. Describe the amendment or correction that you wish us to make:
_____
_____

4. Describe why you think the amendment or correction that you are requesting is appropriate or necessary:
_____

5. Identify any other persons or entities you believe have received your health information and need to be notified of the amendment/correction that you are requesting.

_____

_____

6. Identify any other persons or entities you believe have received your health information and need to be notified of the amendment/correction that you are requesting.

_____

_____

Information about Your Amendment/Correction Rights

We will not process your request for an amendment/correction of your health information if it is not made in writing on this Form or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if the extra time is needed), and will inform you in writing as to whether the amendment will be made or denied. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person who created the information is no longer available to make that amendment;
- Is not part of the information we keep about you;
- Is not part of the information that you would be allowed to see or copy; or
- Is determined by us to be accurate and complete.

If we deny your requested amendment, we will tell you in writing how to submit a statement of disagreement or a complaint, or to request that we include your amendment request in your health information that we maintain.

You also have the right to send us a written addendum to be added to your PHI. Your addendum must be limited to 250 words for each item you believe is incomplete or incorrect. You must clearly indicate that you want the addendum to be included in your PHI.

By submitting this form, I hereby request the organization to amend or correct my health information, as described above, that the organization maintains.

Check the following: I _____ agree or _____ do not agree that if the organization agrees to my request, the organization may provide the amendment/correction to relevant third parties, including, but not limited to, the individuals I identified above, and third parties which the organization contracts to provide services to or on behalf of the organization.

Name: _____

_____

SIGNATURE

I have read and understand the above information:

Signature of Member, Parent/Guardian, Personal Representative:_____

Date: _____

Relationship if signed by other than Member/Participant:_____

Note that, if not already provided, we may require verification of the authority of a Personal Representative before this request will be considered complete.

If request is made by a Parent/Guardian, complete the following: Member is a minor ____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please Return This Completed Form To:
Community Health Group • Member Services • 2420 Fenton Street, Suite 100 • Chula Vista, CA 91914

FORM 5

DENIAL OF A REQUEST FOR CORRECTION/AMENDMENT BY COMMUNITY HEALTH GROUP

Dear _____:

CHG has reviewed your request to amend/correct your health information and has determined that it must deny your request. The following is information as to the basis for our denial and your rights regarding the denial.

1. Basis for the denial:

_____

_____

2. You have the right to submit a written statement disagreeing with our decision to deny your request for an amendment/correction. Your written statement can be no longer than 3 pages and you must submit the written statement to the Chief of Regulatory and Legal Affairs/Compliance Officer at:

   Community Health Group
   Attention: Chief of Regulatory and Legal Affairs/Compliance Officer
   2420 Fenton Street, Suite 100
   Chula Vista, CA 91914

   We may choose to write a rebuttal statement in response to your statement of disagreement. If we do so, we will provide you with a copy of that rebuttal statement. For all subsequent disclosures of your health information that we make and that are the subject of the request for amendment/correction, we will include your request for amendment/correction, our denial, your statement of disagreement and our rebuttal statement, if any, or a summary of such information.

3. If you choose not to submit a written statement disagreeing with our decision to deny your request for amendment/correction, you may request us to provide your request for amendment/correction and our denial with any subsequent disclosures of your health information that is the subject of the request for amendment/correction. To make such a request, submit your request in writing to the Chief of Regulatory and Legal Affairs/Compliance Officer at:

   Community Health Group
   Attention: Chief of Regulatory and Legal Affairs/Compliance Officer
   2420 Fenton Street, Suite 100
   Chula Vista, CA 91914

4. You have the right to submit a complaint to CHG by contacting the Chief of Regulatory and Legal Affairs/Compliance Officer at:
   Community Health Group
   Attention: Chief of Regulatory and Legal Affairs/Compliance Officer

2420 Fenton Street, Suite 100
Chula Vista, CA 91914

You also have a right to submit a complaint about CHG to the Secretary of the Department of Health and Human Services ("Secretary"). If you wish to submit a complaint to the Secretary about CHG's decision to deny your request for amendment/correction, you must file it in writing, either on paper or electronically. The complaint must name CHG and describe how you believe CHG violated your right to have your health information amended or corrected. You must file the complaint within 180 days of the time CHG denied your request.

If you have any questions or concerns, please contact the Member Services Department at 1-800-224-7766.

FORM 6

NOTICE TO THIRD PARTIES REGARDING AN AMENDMENT/CORRECTION TO HEALTH INFORMATION BY COMMUNITY HEALTH GROUP

Dear _____:

The following is to notify you of an amendment/correction to the health information of the individual identified below. You are receiving this Notice because either CHG has disclosed the information that is the subject of the amendment/correction to you or the individual has identified you as requiring notice of the amendment/correction. Please review the information below and amend your records accordingly.

1. Name of requesting individual:

_____

2. Description of the information that is the subject of the amendment/correction:

_____

3. Description of the amendment/correction **[attach documents as necessary]**:

_____

_____

Thank you for your prompt attention to this matter.

FORM 7

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION BY COMMUNITY HEALTH GROUP

1. Name of requesting individual:

_____

2. Date of request:

_____

3. Time period of disclosures for which you are requesting an accounting (the list we provide will include disclosures made within the last six years, unless you specify a shorter period):

_____

Information about your rights to receive an accounting

You have the right to get a list of instances in which we have disclosed your health information. The list will not include certain disclosures including, but not limited to, those we have made for our treatment, payment and health care operations purposes, those that are a byproduct of another permissible use or disclosure, those made under an authorization provided by you, those made directly to you or to your family or friends or through our facility directory, or for disaster relief purposes. Neither will the list include disclosures we have made for national security purposes or to law enforcement personnel, or disclosures made before April 14, 2003.

We will respond to your request for an accounting within 60 days (or 90 days if the extra time is needed).

Charges for Accounting

The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period. You have the right to withdraw or modify your request by writing to us in order to avoid or reduce the fee.

Where to Submit this Form

You must submit this completed form to the Chief of Regulatory and Legal Affairs/Compliance Officer at:

Community Health Group
Attention: Chief of Regulatory and Legal Affairs/Compliance Officer
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

By submitting this form, I hereby request CHG to provide me with an accounting of disclosures of my health information made by CHG.

Name: _____

Signature: _____

Date: _____

Name of Workforce Member who received this form: _____

Date form received: _____

FORM 8

ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION BY COMMUNITY HEALTH GROUP

1. Disclosure to **[insert name of entity or person who received the protected health information unless paragraphs (e) or (f) apply]**

   a. Date of Disclosure(s):

   _____

   b. If known, the address of the person or entity who received the information:

   _____

   _____

   c. Brief description of the information disclosed:

   _____

   _____

   _____

   d. The purpose for the disclosure (if applicable, may instead attach a copy of the individual's request for disclosure or a copy of a request for a disclosure that did not require an authorization, or did not require providing the individual with an opportunity to agree or object):

   _____

   _____

   e. **[The following is applicable if CHG made multiple disclosures of health information to one entity or person for a single purpose at the individual's request or for purposes that did not require an authorization or providing the individual with the opportunity to agree or object]** The above information applies to the first disclosure that CHG made to such individual or entity. In addition, CHG made subsequent disclosures of your health information to such individual or entity for the same purpose as follows: **[insert the frequency, periodicity, or number of disclosures made during the accounting period]**. The last date that CHG made a disclosure of your health information to this person or entity during the accounting period was **[insert date]**.

Name of Workforce Member who completed this form: _____

Signature: _____

Date: _____

FORM 9

ACCOUNTING OF DISCLOSURES LOG

THE FOLLOWING LOG CAN BE MAINTAINED IN PAPER OR ELECTRONIC FORM. This log is to be used in conjunction with the section in the Policy on Individuals' Rights regarding Accounting Rights ("Policy"). Consult the Policy to determine when a disclosure of Protected Health Information ("PHI"), as defined in the Policy, must be logged. For those disclosures that must be logged, complete the following for <u>each</u> such disclosure:

1. DISCLOSURE [Complete Paragraphs (a) – (d) unless Paragraphs (f) or (g) apply]

a. Insert the name of the entity or person to whom the PHI was disclosed:

_____

b. Insert the date of the disclosure:

_____

c. If known, insert the address of the person or entity listed in # 1 above:

_____

d. Provide a brief description of the PHI that was disclosed:

_____

_____

e. Summarize the purpose for the disclosure (if applicable, may instead attach a copy of the individual's request for a disclosure or the request for disclosure that did not require an authorization, or an opportunity to agree or object instead of describing the purpose for the disclosure (consult the Policy on Uses and Disclosures of PHI for which Authorization or Opportunity to Agree or Object is Not Required for guidance)):

_____

_____

_____

f. **[The following is applicable if CHG made multiple disclosures of health information to one entity or person for a single purpose at the individual's request or for purposes that did not require an authorization or providing the individual with the opportunity to agree or object]** The above information applies to the first disclosure that CHG made to such individual or entity. In addition, CHG made subsequent disclosures of your health information to such individual or entity for the same purpose as follows: **[insert the frequency,**

periodicity, or number of disclosures made during the accounting period]. The last date that CHG made a disclosure of your health information to this person or entity during the accounting period was **[insert date]**.

Name of Workforce Member completing this form:_____

Signature:_____

Date:_____

2. FOR ALL OTHER DISCLOSURES, COPY THE TEXT ABOVE AND COMPLETE.

FORM 10

REQUEST FOR RESTRICTION ON USES AND DISCLOSURES OF HEALTH INFORMATION BY COMMUNITY HEALTH GROUP

Date of Request: _____

Identification of Member/Participant: (The following information is needed for verification. Please complete all applicable items.)

Name of Member: _____ Date of Birth: _____
Phone number where we can reach you, if we need to contact you to process your request (required):
_____
Plan you enrolled in: ____ Medicare ____ Cal MediConnect ____ Medi-Cal
Member ID card number (if applicable):_____
Subscriber Name (if different from Member): _____
Subscriber's Relationship to Member (if applicable):_____
Subscriber's Employer Name (if applicable): _____

Information on Your Rights to Request a Restriction

You have the right to ask us to restrict how CHG uses and discloses your health information for purposes of treatment, payment or health care operations (See Notice of Privacy Practices for more information on these types of uses and disclosures). You also have the right to ask us to restrict disclosures that we make to those family members or others involved in your care or involved in payment for your care or for notification purposes. We are not required to agree to your request, except for restrictions covered by 45 C.F.R. § 164.522(a) (pertaining to disclosures to a health plan for the purpose of carrying out payment or health care operations) and the restriction applies to PHI that pertains solely to a health care item or service which the member paid for out of pocket. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment. If we do not agree to your request we will notify you of our decision in writing.

Verification Questions

The answers you provide will be used to verify your identity if your request for a restriction is approved by Community Health Group and you call for your protected health information. You must provide this information:

Your Mother's date of birth: (answer in the following 8-digit format: 11231949 for November 23, 1949)

___ ___ ___ ___ ___ ___ ___ ___

Your Mother's Maiden Name:

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Please DO NOT provide anyone else with the answers to these questions. When you call, Community Health Group will ask you to provide the information you gave us above, so we can verify your identity. Note that we ask these questions because the answers should be easy for you to remember. Community Health Group does not know your mother's date of birth or credit card number.
Please keep a copy of this form for reference

REQUESTED RESTRICTIONS

Please describe your request as thoroughly as possible (attach more sheets as needed):
_____
_____

_____
_____
_____

MAILED COMMUNICATIONS

Please note that, regardless of any restriction Community Health Group agrees to, communications, including communications that include PHI, will continue to be mailed to the current address we have on file for you. Therefore, any person in your household may see such communications and may be prompted to question you about them.

By submitting this form, I hereby request CHG to restrict uses and disclosures of my health information as described above. I understand that CHG is not required to agree to my request.

SIGNATURE

I have read and understand the above information:

Signature of Member, Parent/Guardian, Personal Representative:_____

Date: _____

Relationship if signed by other than Member/Participant:_____

Note that, if not already provided, we may require verification of the authority of a Personal Representative before this request will be considered complete.

If request is made by a Parent/Guardian, complete the following: Member is a minor ____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please Return This Completed Form To:
Community Health Group • Member Services • 2420 Fenton Street, Suite 100 • Chula Vista, CA 91914

Name of Workforce Member who received this form: _____
Date form received: _____

FORM 11

GRANTING OF A REQUEST FOR RESTRICTION ON USES AND DISCLOSURES OF HEALTH INFORMATION BY COMMUNITY HEALTH GROUP

Dear _____:

We have reviewed your request for CHG to restrict its uses and disclosures of your health information and have determined that CHG will grant your request. Accordingly, we agree to restrict our uses and disclosures of your health information as follows: **[insert a description of the agreed to restriction and, if CHG will only agree to a restriction in part, describe that restriction]**.

The restriction shall only be applicable to our uses and disclosures of your health information for treatment, payment and health care operations purposes, for disclosures to those involved in your care or payment for that care, and for notification purposes. CHG shall take reasonable steps to abide by the agreed to restriction.

The restriction that you requested shall not apply to our uses and disclosures of your health information if you are in need of emergency treatment. The restriction that you requested shall also not apply to our uses and disclosures of your health information to the Secretary of the Department of Health and Human Services to investigate or determine CHG's compliance with federal privacy laws. It also shall not apply for uses and disclosures related to our facility directory, nor to uses and disclosures for which the law does not require us to obtain your consent or prior authorization.

Please contact the Member Services Department at 1-800-224-7766 if you have any questions or would like additional information.

FORM 12

DENIAL OF A REQUEST FOR RESTRICTION
BY COMMUNITY HEALTH GROUP

Dear _____:

CHG has reviewed your request for a restriction of our uses and disclosures of your health information and has determined that it must deny your request **[insert whether denial is in whole or in part].** The following is information as to the basis for our denial.

1. **[Applicable if the denial is only in part]** Description of the restriction that is being denied:

2. Basis for the denial:

If you have any questions, please contact the Member Services Department at 1-800-224-7766.

FORM 13

DOCUMENTATION OF A GRANTED RESTRICTION ON USES AND DISCLOSURES OF HEALTH INFORMATION BY COMMUNITY HEALTH GROUP

1. Name of requesting individual: _____

2. Date of request: _____

3. Describe the requested restriction on CHG's uses and disclosures of the individual's health information: _____

_____

4. Describe the restriction on uses and disclosures of the individual's health information to which CHG has agreed **[if CHG has only agreed to a restriction in part, document the restriction to which CHG has agreed]**: _____

_____

5. List all Departments, functions and individuals that will be provided a copy of this Form in order to implement the agreed to restriction: _____

By signing below, I agree that I will promptly provide copies of this Form to the Departments, functions and individuals listed in # 5 above.

Name of Workforce Member who Completed this form: _____

Signature: _____

Date: _____

FORM 14

REVOCATION OF A RESTRICTION ON USES AND DISCLOSURES OF HEALTH INFORMATION BY COMMUNITY HEALTH GROUP

Dear _____:

[Use the following language if you will be notifying the individual of termination of the restriction, but will not be attempting to obtain the individual's agreement to the revocation] This letter is to inform you that CHG is hereby terminating its agreement to the restriction of its uses and disclosures of your health information. This revocation shall apply to all health information that we create or receive about you in the future. The revocation does not apply to health information that we created or received while the restriction was in place.

Please contact the Member Services Department at 1-800-244-7766 if you have any questions.

[Use the following language if you will be attempting to obtain the individual's agreement to the revocation] This letter is to inform you that CHG would like to terminate its agreement to the restriction of its uses and disclosures of your health information. **[Optional: insert reasons why CHG wishes to terminate the restriction]**. If you agree to this revocation, the termination shall apply to all of your health information created or received by CHG at any time, including that created or received while the restriction was in place.

If you agree to allowing CHG to revoke the restriction, please sign below and return a copy of this letter to the Chief of Regulatory and Legal Affairs/Compliance Officer at:
Community Health Group
Attention: Chief of Regulatory and Legal Affairs/Compliance Officer
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

Sincerely,

[Insert name of CHG]

By:_____

Its:_____

By signing below, I hereby agree to CHG's request to terminate the restriction referenced in this letter.

Name:_____

Signature:_____

Date:_____

Name of Workforce Member who received this Form:_____

Date Form received:_____