

## HIPAA Forms for use by Florida lawyers

The following HIPAA forms are recommended by The Florida Bar Health Law Section HIPAA Committee for use by the bar in Florida as being consistent with Federal HIPAA privacy and confidentiality rules found at 45 CFR 160, et. seq.

As is the case when using forms, they do not constitute legal advice. Consult competent counsel before using them.

Suggestions to improve these forms or to add additional forms are welcome.

Respectfully submitted September 24, 2003, by The Florida Bar Health Law Section HIPAA Committee, James M. Barclay, chair.

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**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION  
UNDER HIPAA RULE 164.508**

You May Refuse to Sign This Authorization

I, \_\_\_\_\_, (hereafter referred to as "Individual") hereby authorize  
\_\_\_\_\_, (hereafter collectively referred to as "you") to  
use and disclose in any form or format a copy of records concerning Individual but only as follows, to:  
\_\_\_\_\_ for the purpose(s) of  
(be specific): \_\_\_\_\_ I specifically authorize you to use

and disclose the following types of super-confidential information (initial where appropriate):

- HIV records (including HIV test results) and sexually transmissible diseases
- Alcohol and substance abuse diagnosis and treatment records
- Psychotherapy records
- Tuberculosis
- All hospital records
- All of the above

I specifically authorize you to use and disclose the following Protected Health Information. Please initial  
one or more of the following, if applicable:

- Written Medical records
- X-rays/MRI/CT
- Billing records
- Prescription records
- Other (specify in detail) \_\_\_\_\_
- All of the above

I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or  
state law; that this Authorization remains effective until the following date: \_\_\_\_\_; the  
following event: \_\_\_\_\_; or until you actually receive a signed  
revocation or until the records retention period required under federal and Florida law has expired,  
whichever first occurs; that I have been given an opportunity to ask questions; that I have received a copy  
of the signed Authorization; that I may inspect a copy of my protected health information to be used or  
disclosed under this Authorization; that you have not conditioned provision of services to or treatment of  
me upon receipt of this signed Authorization; and that I may refuse to sign this Authorization. My refusal  
to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or  
ability to obtain treatment, except as provided on this form. If the purpose of this Authorization is for the  
use and/or disclosure of health information for a research study, and I refuse to sign this Authorization, you  
reserve the right to deny treatment associated with such research. If the purpose of this Authorization is to  
disclose health information to another party based on health care that is provided solely to obtain such  
information, and I refuse to sign this Authorization, you reserve the right to deny that health care. I  
understand that I may inspect or copy the information that is used or disclosed. I understand that I may  
revoke this Authorization at any time by notifying you in writing, except to the extent that action has been  
taken in reliance on this Authorization; or if this Authorization is obtained as a condition of obtaining  
insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the  
policy itself.

A copy of this signed form will be provided the individual.

By Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print name and sign)

Or  
By Patient's Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print name, sign, and describe authority below)

\_\_\_\_\_  
\_\_\_\_\_

Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee

**ACKNOWLEDGMENT OF RECEIPT HIPAA PRIVACY NOTICE  
UNDER HIPAA RULE 164.520**

You May Refuse to Sign This Acknowledgment

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices of \_\_\_\_\_ this \_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Please print your name

\_\_\_\_\_  
Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority \_\_\_\_\_.

Thank you and if you have any questions about this form or the attached Notice, please contact Privacy Officer, \_\_\_\_\_, \_\_\_\_\_.

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**USE ONLY**

I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

- It was emergency treatment \_\_\_\_\_
- I could not communicate with the patient \_\_\_\_\_
- The patient refused to sign \_\_\_\_\_
- The patient was unable to sign because \_\_\_\_\_
- Other (please describe) \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of other witness, if any

**REQUEST TO INSPECT, COPY OR SUMMARIZE UNDER HIPAA RULE 164.524**

Return completed form to Privacy Officer, \_\_\_\_\_, \_\_\_\_\_:

Please note that we may deny your request to inspect, copy or summarize records if you are not the patient or the patient's legal representative, if we do not have the records, or in other circumstances. If we deny your request, you may ask us to review that decision.

**COMPLETE AS APPLICABLE:**

1. This request pertains to the records of \_\_\_\_\_.
2. I want to inspect the entire medical record (including clinical and billing information) \_\_\_ or I want to inspect only the following type of records: \_\_\_\_\_
  - I wish to inspect the records from \_\_\_ am/pm to \_\_\_ am/pm on \_\_\_\_, \_\_\_\_, 20\_\_.
  - I will bring with me the following persons: \_\_\_\_\_ and I hereby authorize \_\_\_\_\_ to disclose and otherwise provide them with full and complete access to the records described above.
  - I agree that original records will not leave the premises and that \_\_\_\_\_'s privacy officer will be present at all times during the inspection. \_\_\_ yes \_\_\_ no.
3. I want a copy of the entire medical record \_\_\_ or only the following records \_\_\_\_\_:
  - I want photocopies \_\_\_ other format: \_\_\_\_\_.
  - The copy will be ready for pick-up at \_\_\_\_, on \_\_\_\_, \_\_\_.
  - I acknowledge I will pay costs in the amount of \_\_\_\_\_ before the copies are released.
4. I want a SUMMARY of the entire medical record \_\_\_ or only the following records: \_\_\_\_\_
  - The summary will be ready for pick-up at \_\_\_ on \_\_\_.
  - I acknowledge I will pay costs in the amount of \_\_\_\_\_ before the summary is released.

By Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print name and sign)

Or  
By Patient's Representative \_\_\_\_\_ Date: \_\_\_\_\_  
(Print name, sign, and describe authority)

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**USE ONLY**

1. Request denied because records were:
  - Not in our possession (and we advised the patient where they were, if known) \_\_\_\_\_
  - From a confidential source that would be revealed if records were disclosed to patient \_\_\_\_\_
  - Other (describe): \_\_\_\_\_
2. Patient requested a review of the denial on \_\_\_\_\_. We have selected \_\_\_\_\_ to review our denial.
3. Upon review of our denial, \_\_\_\_\_'s recommendation was \_\_\_\_\_.
4. Copy of records in format requested not provided because:
  - Impracticable \_\_\_\_\_
  - Patient refused payment of copying charge \_\_\_\_\_
  - Patient failed to pick-up \_\_\_\_\_
  - Other (describe) \_\_\_\_\_
5. Copy of records released to \_\_\_\_\_ on \_\_\_\_\_.
6. Summary of records released to \_\_\_\_\_ on \_\_\_\_\_.

\_\_\_\_\_  
Privacy Officer  
TAL:45017:1

\_\_\_\_\_  
Date

Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee

**RESPONSE TO RECORDS REQUEST  
UNDER HIPAA RULE 164.524**

Sent to : \_\_\_\_\_

Dear: \_\_\_\_\_

On \_\_\_\_\_, you submitted a request to us pertaining to the records of \_\_\_\_\_.

**COMPLETE AS APPLICABLE:**

1. We are ready to prepare the copy \_\_\_ summary \_\_\_ (check one) you requested. The cost for this service is \$ \_\_\_\_\_. Upon receipt of this charge, we will provide the requested records. Please contact our Privacy Officer, \_\_\_\_\_, \_\_\_\_\_ to arrange a time to pick-up the records. If you prefer, we will mail them to you. Please call to determine the additional postage cost and let us know where you want us to mail the records.
2. We are ready to provide you with access to inspect the records as you requested. Your appointment time is from \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm on \_\_\_\_\_ at \_\_\_\_\_. Please contact our Privacy Officer at least 24 hours in advance if you will be unable to make this appointment.
3. We are denying all \_\_\_ some \_\_\_ (as indicated below) of your request because:
  - \_\_\_ We do not have the following records: \_\_\_\_\_
  - \_\_\_ We believe you may obtain the records by contacting: \_\_\_\_\_
  - \_\_\_ We do not know where you may obtain the records
  - \_\_\_ It was impracticable for us to produce the copy or summary in the format you requested. Please contact our Privacy Officer if you would like paper copies.
  - \_\_\_ We cannot give you access to the following records \_\_\_\_\_ because:
    - \_\_\_ You lack authority under Florida law to access these records (e.g., the patient has not given you authority in writing, the written authority has been revoked, the records are super-confidential and you have only a general authority).
    - \_\_\_ The information was given to us on a confidential basis and revealing the records would disclose the source of the information.
    - \_\_\_ The information has been compiled in anticipation of litigation.
    - \_\_\_ The information is protected by the Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. §263a) or the Privacy Act (5 U.S.C. §552a).
    - \_\_\_ A licensed health care provider has determined, in the exercise of his or her professional discretion, that disclosing the records would endanger the health or safety of you or another person.
    - \_\_\_ Other: \_\_\_\_\_
4. If you disagree with our decision, you may file a written complaint with Privacy Officer.

\_\_\_\_\_  
Privacy Officer

\_\_\_\_\_  
Date

Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee

**REVOCATION OF HIPAA AUTHORIZATION FORM  
UNDER HIPAA RULE 164.508**

Return completed form to Privacy Officer, \_\_\_\_\_, \_\_\_\_\_:

\_\_\_\_\_  
Please be advised that I, the undersigned, do hereby revoke that certain Authorization (describe in detail the recipient of the records) between the \_\_\_\_\_, (hereafter \_\_\_\_\_) and \_\_\_\_\_ dated the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

This revocation will take effect upon actual receipt unless we, our employees, or our agents have already acted based on the underlying Authorization.

By Patient: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
(Print name and sign)

Or

By Patient's Representative \_\_\_\_\_ Date: \_\_\_\_\_

(Print name, sign, and describe authority)

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\_\_\_\_\_ **USE ONLY**

Date revocation received: \_\_\_\_\_

\_\_\_\_\_  
Privacy Officer

\_\_\_\_\_  
Date

Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee

REQUEST TO AMEND PROTECTED HEALTH INFORMATION  
UNDER HIPAA RULE 164.526

**A. THE PURPOSE OF THIS REQUEST FORM**

Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may request that we amend or correct your protected health information. Accordingly, this form is being made available to you should you wish to request such an amendment or correction. The HIPAA Privacy Rules allow you to make such a request, but do not necessarily require us to agree to your request. Note that your request to amend or correct your records is limited, in most instances, to the records that we created. Please see our Notice of Privacy Practices for further information.

**B. YOUR REQUESTED AMENDMENT OR CORRECTION**

In the space provided below, please describe what amendment or correction to your protected health information you are requesting. Please be as detailed as possible, and if you have any questions, do not hesitate to seek our assistance.

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**C. THE REASON FOR YOUR REQUEST**

In order for us to decide whether we will agree to your requested amendment or correction, please describe the specific reasons for your request.

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**D. OTHER INFORMATION CONCERNING YOUR REQUEST**

If you have any questions regarding your request, or the HIPAA Privacy Rules that apply to this request, please contact our Privacy Officer at \_\_\_\_\_.

Name of Patient (please print) \_\_\_\_\_  
[Patient identifier here] \_\_\_\_\_  
Date of birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Patient's Signature \_\_\_\_\_

OR

Personal Representative (please print) \_\_\_\_\_  
Personal Representative Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee

**REQUEST TO RESTRICT USES AND DISCLOSURES  
OF PROTECTED HEALTH INFORMATION UNDER HIPAA RULE 164.522**

**A. THE PURPOSE OF THIS REQUEST FORM**

Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may request us to restrict the use and disclosure of your protected health information. Accordingly, this form is being made available to you should you wish to request such a restriction. The HIPAA Privacy Rules allow you to make such a request, but do not require us to agree to your request. Please see our Notice of Privacy Practices for further information.

**B. YOUR REQUESTED RESTRICTION**

In the space provided below, please describe what restrictions on the use and/or disclosure of your protected health information you are requesting. Please be as detailed as possible, and if you have any questions, do not hesitate to seek our assistance.

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**C. OTHER INFORMATION CONCERNING YOUR REQUEST**

This request is governed by the HIPAA Privacy Rules. Even if we agree to your requested restriction, that agreement will not prevent us from making uses or disclosures as otherwise permitted or required under the HIPAA Privacy Rules or our Notice of Privacy Practices. Also, if our Privacy Officer agrees to your requested restriction, we may later terminate that agreement by informing you of that termination.

If you have any questions regarding your request, the HIPAA Privacy Rules, or our Notice of Privacy Practices that apply to this request, please contact our Privacy Officer at: \_\_\_\_\_.

Name of Patient (please print) \_\_\_\_\_  
[Patient Identifier] \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_

Patient's Signature \_\_\_\_\_

OR

Personal Representative (please print) \_\_\_\_\_  
Personal Representative Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee

**REQUEST FOR ACCOUNTING OF DISCLOSURES  
UNDER HIPAA RULE 164.528**

Return completed form to Privacy Officer, \_\_\_\_\_, \_\_\_\_\_

Please note that we may deny your request for accounting of disclosures if you are not the patient or the patient's legal representative, if the disclosure was made to you or your legal representative, if it was made to others for treatment, payment or healthcare-operations purposes, or in other circumstances. The first Accounting in any 12-month period is without charge. Other Accountings within that period may be subject to cost-based fees.

**COMPLETE AS APPLICABLE:**

1. Please provide me with an accounting of disclosures pertaining to the records of \_\_\_\_\_.
2. Please include disclosures made from \_\_\_\_\_, \_\_\_\_\_ to \_\_\_\_\_, \_\_\_\_\_.
3. Please provide me with the accounting in the following format: photocopies \_\_\_ other \_\_\_\_\_.
4. The accounting will be ready for pick-up at \_\_\_\_\_, on \_\_\_\_\_, \_\_\_\_\_.
5. I acknowledge I will pay costs in the amount of \_\_\_\_\_ before the accounting will be released.

By Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print name and sign)

Or  
By Patient's Representative \_\_\_\_\_ Date: \_\_\_\_\_  
(Print name, sign, and describe authority)

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**USE ONLY**

1. Request for accounting denied because:  
Disclosures occurred more than six years before the date of the request \_\_\_\_\_  
Disclosures occurred prior to April 14, 2003 \_\_\_\_\_  
Patient refused to pay costs \_\_\_\_\_  
Other \_\_\_\_\_
2. Business Associates instructed to provide \_\_\_\_\_ with an accounting of their disclosures on: \_\_\_\_\_
3. Disclosures released to individual on \_\_\_\_\_.

\_\_\_\_\_  
Privacy Officer

\_\_\_\_\_  
Date

Approved September 24, 2003  
 Florida Bar Health Law HIPAA Committee

ACCOUNTING OF DISCLOSURES OF  
 PROTECTED HEALTH INFORMATION UNDER HIPAA RULE 164.528

This is an accounting under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**I. INTRODUCTION**

Under HIPAA, you have the right, with some exceptions, to receive an accounting of disclosures of protected health information made by us and our business associates. The first Accounting in any 12-month period is without charge. Other Accountings within that period may be subject to cost-based fees. The accounting you requested is set forth below. Please note that the Privacy Rules do not require Accounting for disclosures prior to April 14, 2003.

**II. ACCOUNTING**

**A. Our Disclosures**

Patient name	Date of disclosure and by whom	Name and address of recipient	Protected health information disclosed	Purpose of disclosure

**B. Business Associates' Disclosures**

Patient name	Date of disclosure and by whom	Name and address of recipient	Protected health information disclosed	Purpose of disclosure

This accounting has been prepared in accordance with the above referenced Privacy Rule and is being furnished to you in compliance with our obligations under the HIPAA Privacy Rules. If you have any questions regarding this Accounting, please contact our Privacy Officer at: \_\_\_\_\_.

Name of Covered Entity \_\_\_\_\_

By: \_\_\_\_\_

Date of Request: \_\_\_\_\_

Date of Accounting: \_\_\_\_\_

Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee

REQUEST TO RECEIVE COMMUNICATIONS OF PROTECTED  
HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION UNDER  
HIPAA RULE 164.522

**I. INTRODUCTION**

Under the HIPAA Privacy Rules, you may request, and we must accommodate, your reasonable request to receive communications of protected health information by alternative means or at an alternative location. We are providing you with this form to make such a request.

**II. REQUESTED ALTERNATIVE METHOD OF COMMUNICATION**

In the space provided below, please describe what alternative means through which you desire to receive communications from us (for example, by voice mail or e-mail).

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**III. ALTERNATIVE ADDRESS FOR CONTACT**

Please state the address of the alternative location or other method of contact that you want us to utilize in communicating with you.

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If you have any questions regarding your request, or the HIPAA Privacy Rules that apply to this request, please contact our Privacy Officer at: \_\_\_\_\_.

Name of Patient (printed) \_\_\_\_\_  
[Patient Identifier] \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_

Patient's Signature \_\_\_\_\_  
Or

Personal Representative \_\_\_\_\_  
Date: \_\_\_\_\_

Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee

**COMPLAINT FORM UNDER HIPAA RULE 164.530**

Individual's name: \_\_\_\_\_

Individual's address: \_\_\_\_\_

Individual's telephone number: \_\_\_\_\_

Individual's record number: \_\_\_\_\_

What is the complaint that you have? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What documents should we review in considering this complaint?

\_\_\_\_\_  
\_\_\_\_\_

Who else might have information about the complaint?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specify the relief sought:

\_\_\_\_\_

We will act on your complaint in a prompt manner and we will advise you of its outcome.

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\_\_\_\_\_ **Use Only:**

Name of Staff Member: \_\_\_\_\_ Title: \_\_\_\_\_

Resolution of complaint: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Privacy Contact \_\_\_\_\_ Date \_\_\_\_\_



Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee

**DOCUMENTATION OF EMPLOYEE TRAINING  
UNDER HIPAA RULE 164.530**

HIPAA requires us to train employees on our health information privacy policies and procedures. All employees with treatment, payment or health care operations responsibilities, which allow access to protected health information, are periodically trained. HIPAA also requires that we keep Documentation that the training was completed for six years after the training.

I, the undersigned, do hereby certify that I have received HIPAA training on the date indicated below:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

This Documentation must be placed in the Employee's Personnel File.

**PRIVACY NOTICE FOR E-MAIL MESSAGES UNDER HIPAA RULE 164.530**

This message is not intended to be a legally binding or legally effective electronic signature. The Documents accompanying this message may contain protected health information (PHI) or other confidential information that is privileged, proprietary, confidential, or otherwise legally exempt from disclosure. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to protect the confidentiality of the information after its stated use has been fulfilled. If this is an e-mail message that contains a forwarded message or is a reply to a prior message, some or all of the contents of this message or its attachments may not have been produced by the sender.

If you are not the intended recipient, you are hereby notified that any retention, disclosure, copying, distribution or action taken in reliance on the contents of these Documents is strictly prohibited. If you have received these Documents in error, please notify the sender immediately at (insert sender's phone or fax number, e-mail address, as applicable) to arrange for their return and delete all copies of this message.

*Approved September 24, 2003  
Florida Bar Health Law HIPAA Committee*

**PROHIBITION ON RE-DISCLOSURE UNDER HIPAA RULE 164.530  
(HIV INFORMATION)**

This information has been disclosed to you from records whose confidentiality is protected by Florida law. Florida law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law.

**PROHIBITION ON RE-DISCLOSURE UNDER HIPAA RULE 164.530  
(SUBSTANCE ABUSE / PSYCHOTHERAPY INFORMATION)**

This information is confidential under Florida and federal law. Federal regulations (42 CFR §§ 2.1 et seq.) prohibit any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

*Approved September 24, 2003  
Florida Bar Health Law HIPAA  
Committee*