Confidentiality and Records Appendix

Page

Acknowledgement of Notice of Privacy Rights and Practices, Form 470-3946

Purpose	Form 470-3946 is used by Department health care facilities having a direct treatment relationship with a client to obtain written acknowledgement of the client's receipt of the notice of privacy rights and practices.
Source	Print or photocopy supplies of this form from the sample in the manual as needed.
Completion	Add the client's name to the form and give it to the client or the client's representative to sign. If you are unable to get the client or the client's representative to sign the form, document your efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained in the case record.
Distribution	File a copy in the case record and give a copy of the form to the client or the client's representative upon request.
Data	The form contains the client's name, authorized signature, and date of signature.

Authorization for Release of Information, Form 470-0461 or 470-0461(S)

Purpose

Forms 470-0461 and 470-0461(S) are designed to secure the client's permission for the Department to investigate items of eligibility. The source of information may also use the form to furnish the requested information.

Source

Complete the form online using the templates on the HHS SharePoint.

Completion

Income maintenance workers may complete this form when it is necessary to obtain information from a source other than the client. Complete a separate form for each source of required information.

NOTE: This form should not be used to request any health care information, including mental health information, substance abuse information, or HIV information. See **Authorization to Obtain or Release Health Care Information, Form 470-3951 or 470-3951(S)**.

The worker completes the identifying information and the description of the information requested. The client (or the person authorized to obtain the information) signs that section to give the authorization. The source of information completes Page 2 of the form. Additional pages may be used if necessary.

Distribution

Send one copy to the source of information with a self-addressed stamped envelope enclosed. Print an extra copy of Page 1 as a control.

When the source of information returns the original copy, destroy the control copy, and file the completed copy in the case record.

Data

To initiate the form, enter:

- The name and address of the source of information.
- The salutation
- The information requested. Be as specific as possible. Include the client's name and the client's address or social security number if they are needed to identify the requested information.

The template enters the worker information and the dates. The date the authorization expires is 60 days from the date the form is signed, unless you have supervisory approval to extend the date.

The client shall sign and date the form after these items have been completed.

The source of information completes the remainder of the form.

Authorization for the Department to Release Information, Form 470-2115

Purpose	Form 470-2115 is designed to secure the client's permission for the Department to release confidential information to persons or agencies outside the Department.
Source	Workers may complete this form online using the template on the HHS SharePoint. This form is available on the Child Support Services Website.
Completion	This form can be completed by a worker or client to request the Department to release information to a person or agency outside the Department. The client must sign and date the form.
Distribution	Keep the form in the case record.
Data	Enter: ▪ The name of the client ▪ The Social Security Number of the client (if applicable) ▪ The name of person or agency the client is authorizing disclosure to and their contact information. ▪ The information that may be released. ▪ The date the authorization expires. The client shall sign and date the form.

Authorization to Obtain or Release Health Care Information, Form 470-3951 or 470-3951(S)

Purpose

Form 470-3951 or 470-3951(S) is a two-way release form used to get the permission of the client or the client's legally authorized representative to:

- Release health information about the client to a third party.
- Obtain health information needed to provide service to the client.

Source

Department staff may complete the English version of this form on line using the template:

- In the public state-approved Service forms folder on Outlook or
- On the HHS SharePoint.

The English version is also printed in pads of 25 three-part precarboned sets. Order supplies from Iowa Prison Industries at Anamosa.

Supplies of the Spanish version of this form can be printed or photocopied from the sample in the manual.

Completion

Staff at Department medical facilities and service workers shall complete this form whenever it is necessary to obtain health information from or release health information to a source other than the client.

Income maintenance workers and service workers may furnish this form to a client who requests that the Department share protected health care information for a purpose other than health care treatment or payment.

Complete a separate form for each source from which information is being requested or to which information is being released.

The worker may complete the identifying information and the description of the information being obtained or released. The client (or the client's personal representative) signs the section to give the authorization.

Distribution

Send one copy to the source of information with a self-addressed stamped envelope enclosed. Keep one copy as a control copy. Give the third copy to the client.

When the source of information returns the original copy, destroy the control copy and file the completed copy in the case record.

Data

To initiate the form, enter:

- The client's name, state or patient ID number, social security number, date of birth, and parent's or guardian's name, if applicable.
- Your name, address, telephone number, and fax number in the first set of agency information.
- The name or agency to which the information is being released, or from which the information is being requested, and the agency's address, telephone number, and fax number.
- In the section "The information released or shared may include," check the applicable boxes. If the "Other" box is checked, describe the information in a specific and meaningful fashion.

Describe any exceptions or limitations under **Other**. Sample entry: The Department may obtain information from, but not release information to, Heartland AEA.

State the purpose for which the information will be used.

- In the **SPECIFIC AUTHORIZATION FOR RELEASE** section, secure the client's or the client's legal representative's initials if mental health evaluation/treatment, AIDS/HIV-related, or substance abuse is to be obtained or released.

NOTE: Only the client or the client's **legally authorized** representative can give consent to release or obtain mental health evaluation/treatment and AIDS/HIV-related information. **Only the client** can give consent to release or obtain substance abuse information.

"Mental health evaluation/treatment information" means oral, written, or recorded information that indicates the identity of a person receiving professional services and which relates to the diagnosis, course, or treatment of the person's mental or emotional condition.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome, based on the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome." "HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"Substance abuse" means the use of chemical substances by persons suffering from chemical dependency, persons who are incapacitated by a chemical substance, substance abusers, or chronic substance abusers.

- Discuss the authorization and explanation paragraph regarding the use of this form and answer any questions raised. Ensure that the client understands the right to revoke the authorization at any time by completing form 470-3949, *Request to End an Authorization*. Explain the consequences of failure to sign the form.
- Ask the client to sign and date the form and enter a date when the authorization is to expire.
- Check the applicable box indicating the relationship of the person who signs the form to the client.
- Obtain the signature of two witnesses for clients who are incapable of signing their name due to a physical or mental disability.

To use this form as the required documentation for the disclosure of mental health information, enter on the back of the form kept in the case record:

- The date.
- The name of recipient of information.
- The information disclosed.
- The name of the person who disclosed the information.

Child Records Query, Form 470-4375

Purpose

Form 470-4375 is designed to inform a current or former client of a request from a parent who is not on the Department's case for information about a mutual child, including medical records, and to obtain the client's response.

Source

Complete this form online using the template on the HHS SharePoint.

Completion

Both the Department income maintenance worker and the client (or the person authorized) complete this form.

A response must be provided to the requester no later than the 20th day.

Distribution

Mail the original and the client's copy of the form to the current or former client's last known mailing address with a self-addressed stamped envelope.

Keep one copy of the form for the case file and track the form by the due date.

Data

To initiate the form, complete the following:

- In the identifying information, enter
  - The client's name and address;
  - The date;
  - The county and worker numbers;
  - The worker's name, phone number, and office address;
  - The names of the parent requesting the information and the child that the information is requested about.
- In the "Information requested" box, indicate what the parent of the child has requested.
- Enter the due date (**ten calendar days** from the date of the letter) in the blank space in the following sentence:

"If we do not get an answer from you by _____, we will decide what information can be shared based on Iowa law."

The client:

- Checks the response box of “agree” or “do not agree” that the Department may share this information.

  If the “do not agree” box is selected, the client needs to give the reason for not agreeing and send copies of any proof to support the reason.
- Signs, dates, and returns the form with copies of any necessary proof to the designated address.

Consent to Obtain and Release Information, Form 470-0429 and 470-0429(S)

Purpose

Form 470-0429 is designed to get the permission of the client or the client's legally authorized representative to:

- Release information about the client to a third party.
- Obtain information needed to provide service to the client.

The Department uses this form to secure or release non-health-related information for purposes of determining a client's eligibility or services. See **Authorization to Obtain or Release Health Care Information, Form 470-3951 or 470-3951(S)**, for information used to authorize exchange of health care information.

Staff from a county case management or central point of coordination office (a county worker) may also use this form.

Source

Department staff may complete this form on line using the template in the public state-approved forms under the Service folder on Outlook.

The form is also printed in pads of 50 forms. Order supplies from Iowa Prison Industries at Anamosa.

Completion

The Department or county worker prepares the form and secures the signature of the client or the client's representative:

- At the initial request for services.
- When the current authorization expires.
- When new services are added to the client's plan.

Distribution

File the original in the case record. Give the copy to the client or the client's representative. Provide a photocopy to each person or agency authorized to share information.

Data

Enter the requested identifying information at the top of the form. Check the applicable box to identify whether a Department worker or a county worker is preparing the form. For a county worker, also enter the name of the county.

List each person or agency authorized to share information with or receive information from the Department or the identified county. In the box to the right of the list, enter the name, phone number, and address of the Department or county worker who is to receive the information.

Describe any exceptions or limitations under **Other**. Sample entry: HHS may obtain information from but not release information to Heartland AEA.

Enter the expiration date if it is other than *"upon termination of services."*

If the client **withdraws** authorization to share information with a listed person or agency, cross out the entry and secure the date and initials of the client or the client's legally authorized representative.

Designation of Personal Representative, Form 470-3948

Purpose	Clients may use form 470-3948 to designate a personal representative. A "personal representative" is someone designated by another as standing in the other's place or representing the other's interest for one or more purposes.
Source	Print or photocopy this form from the sample in the manual.
Completion	The client wanting to use this form to designate a personal representative completes the form and gives or sends it to: ▪ The caseworker, ▪ The Department's Security and Privacy Office, or ▪ A facility privacy official. NOTE: Use of this form is not mandatory. A client may write a letter designating a personal representative. If you know the client, the client may also verbally inform you of the client's choice of personal representative and you can document the client's choice in the case file.
Distribution	Give a copy of the form to anyone requesting it. File the form in the case record.
Data	The client completes the needed information and signs the form. You will not need to enter any information.

Electronic Security Information, Form 470-2078

Purpose

Form 470-2078 is required to attain a security authorization for Department employees and contractors for the access to electronic systems and files needed for their work.

Source

Department supervisors can access this form through the public state-approved forms folder on Outlook, under "LAN/WAN/MF Access." Choose the "Security Information Form." Be sure to check "Enable macros" when you open the form.

Completion

Department supervisors complete this form to add, delete, or change computer access for their employees and contractors. This includes:

- Electronic mail access and mailbox.
- Mainframe authorization (requires both CICS and NES access).
- Medicaid systems access, including MMIS Medically Needy subsystem access.
- Network access, including remote access. (Form **470-4068, Network Share Request** is also available separately.)
- ICAR access. (Form **470-4069, ICAR Database Request** is also available separately.)
- FACS access. (Form **470-4070, FACS Database Request** is also available separately.)

NOTE: **Only** supervisors can complete the form. The information entered on the form is confidential. Nonsupervisory staff will not be able to access the form. (Nonsupervisory staff can access form **470-4068, Network Share Request** separately.)

The choices on the first page of the form cause other pages to generate. When all of the required information is completed, double-click on the box at the bottom of the page to generate the other pages needed.

If you chose mainframe access, there is a similar box to double-click at the bottom of the mainframe page to generate more forms.

When you exit the form, do not save changes. If you want a record of what you requested, print the form before closing it.

Each form contains information for only one person. To make a request for another employee, select the "Security Information Form" again from Outlook, and complete the process.

Distribution

Send the completed form to the Division of Data Management via E-mail. From the “File” menu, select “Send.” This will create an E-mail message with the request attached.

Enter “DHS, Security” in the “To:” field. In the “Subject” field, enter the name of the person whose access is in question and the type of request (add, delete, or change).

Data

The system enters the current date. On the first page, the supervisor must enter:

- The type of action requested.
- For a change request, the specific system access to be changed.
- The user’s classification and duties.
- The counties where the user works.
- The worker numbers assigned to the user at those locations.
- The systems that the user needs access to.
- The user’s CICS/NES user identification number, if already issued.
- The user’s e-mail user identification number, if issued.
- The user’s name and office phone number.
- The user’s mother’s maiden name.
- The user’s social security number and birth date.
- The supervisor’s name and worker number.
- The supervisor’s e-mail user-identification number.
- The supervisor’s telephone number, including the area code.
- The address of the user’s work location, including the county.
- Whether the user is a state employee or a contractor.
- The end date of the contract, if the user is a contractor.
- What mainframe and LAN/WAN access is requested.
- The systems that the user needs access to. (For access to the MMIS Medically Needy subsystem, check “Other” on the “Mainframe Authorization” Request page and specify this subsystem.)

Fees for Examining and Copying Records, Reference Card RC-0063

Purpose	Reference Card RC-0063 is designed to meet requirement for Department offices to post the charges for the costs of examining and copying public records in the custody of the Department.
Source	Print or photocopy this poster from the sample in the manual.
Completion	Offices involved in programming in response to requests for records that are stored electronically may wish to be more specific about charges for programming costs.
Distribution	Each office where members of the public may request to examine or obtain a copy of a public record should post this form or something similar.
Data	Data on the form are based on Department policy at **1-C, Fees**.

HIPAA Complaint, Form 470-3981

Purpose	Form 470-3981 may be used to complain about the Department's policies or procedures implementing the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, and federal regulations (45 CFR Parts 160 and 164). This form is not to be used to file an appeal of a decision made by the Department in regard to a HIPAA privacy request.
Source	Print or photocopy this form from sample in the manual.
Completion	A person wanting to complain may complete the form and mail it to the HIPAA Security and Privacy Office. Use of this form is not mandatory. A person may also complain by sending a letter or e-mail to the HIPAA Security and Privacy Office. If a person complains in person or through a telephone conversation and is unable to put the allegation in writing, you may complete the form on behalf of that person. Make a notation on the form that you have completed it on behalf of the complainant. Forward the complaint to the HIPAA Security and Privacy Office.
Distribution	Give a copy of the form to anyone requesting it. If you should receive a completed form, mail it to the HIPAA Security and Privacy Office by the end of the next working day.
Data	The complainant completes the identifying information and the statement of the complaint. You will not need to enter any information except as described above when completing the form on behalf of a person who is unable to complete the form.

Record of Disclosure of Health Information, Form 470-4015

Purpose

Form 470-4015 is designed to notify the HIPAA Security and Privacy Office or the facility privacy official when Department staff disclose protected health information.

Source

Complete this form on line using the template in the public state-approved forms folder on Outlook.

Completion

Complete this form when you have made a disclosure of protected health information in one of the following categories:

- Accidental disclosures,
- Disclosures about suspected victims of abuse, neglect or domestic violence,
- Disclosures by whistle blowers,
- Disclosures for averting a threat to health or safety,
- Disclosures for cadaveric organ, eye, or tissue donation,
- Disclosures for health oversight activities,
- Disclosures for judicial and administrative proceedings,
- Disclosures for law enforcement purposes,
- Disclosures for public health activities,
- Disclosures for specialized government functions, except for national security or intelligence purposes,
- Disclosures to coroners, medical examiners, and funeral directors, or
- Disclosures to meet requirements of law.

Do **not** complete the form when you have made a disclosure of protected health information in one of the following categories:

- Disclosures as part of a limited data set in accordance with policies,
- Disclosures for national security or intelligence purposes,
- Disclosures incident to a use or disclosure otherwise permitted or required,
- Disclosures made before April 14, 2003,
- Disclosures made pursuant to an authorization,

- Disclosures to a person involved in the client's care or other notification,
- Disclosures to carry out treatment, payment and health care operations, or
- Disclosures to the client regarding protected health information about the client.

Distribution — Send one copy to the Security and Privacy Office or the facility privacy official. Keep one copy for the client file.

Data — Complete the identifying information, check the category of the disclosure, and provide a brief explanation of the protected health information that was disclosed. The person who made the disclosure signs the form.

Request for Access to Health Information, Form 470-3952

Purpose

A client may use form 470-3952 to request access to or obtain a copy of the client's protected health information.

Source

Print or photocopy this form from sample in the manual.

Completion

If necessary, help the client or the client's personal representative to complete the form with the appropriate personal identifier for the client's circumstances.

The Department Security and Privacy Office or facility privacy official shall complete the form and act on the client's request:

- Within 30 days from the date on the request if the information is on site or
- Within 60 days from the date on the request if the information is not maintained or accessible to the Department on site.

The Security and Privacy Office or facility privacy official may extend the time for an additional 30 days if additional time is needed to act. If a 30-day extension is needed, the Security and Privacy Office or facility privacy official shall notify the client in writing of the reasons for the delay.

If the request is granted, the Security and Privacy Office or facility privacy official shall supply the requested information and charge the client any applicable fees.

Distribution

Facility workers shall give one copy to the client and send one copy to the person acting as the facility privacy official. Field offices shall give one copy of the form to the client and send one copy to the Department's Security and Privacy Office.

Data

To initiate the form, enter:

- The client's name.
- The date of the request.
- The client's address.
- The client's state or patient ID number or social security number.
- The client's telephone number and date of birth.

Check the applicable program (Medicaid, Hawki, or facility).

The client or the client's personal representative shall enter the period for which access to the client's health information is wanted and the personal health information desired.

Request for List of Disclosures, Form 470-3985

Purpose	Clients may use form 470-3985 to request a disclosure of the protected health information that the Department has released to another person or agency.
Source	Print or photocopy this form from sample in the manual.
Completion	The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Privacy Office or to the facility privacy official. The privacy official in the facility or the Security and Privacy Office, acting for Medicaid and Hawki, shall make the final decision on whether to make the disclosure in time to release the information to the client no later than 60 days after receiving a completed form 470-3985. The Security and Privacy Office or facility privacy official may extend the 60 days for one 30-day period if the Security and Privacy Office or facility privacy official notifies the client in writing of the reasons for the delay and the date by which a decision will be made.
Distribution	Give a copy of the form to anyone requesting it. If you should receive a form, forward it to the Security and Privacy Office or give it to your facility privacy official by the end of the next working day.
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the sections identifying whose health information is requested and the period for which it is requested.

Request to Amend Health Information, Form 470-3950

Purpose	Clients may use form 470-3950 to request that protected health information in a client's designated record set be amended.
Source	Print or photocopy this form from sample in the manual.
Completion	The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Security and Privacy Office or to the facility privacy official. The facility privacy official or the Security and Privacy Office, acting for Medicaid and Hawki**,** shall make the final decision on whether to agree to the requested amendment no later than 60 days after receiving a completed form 470-3950. The Security and Privacy Office or facility privacy official may extend the 60 days for one 30-day period if the Security and Privacy Office or facility privacy official notifies the client in writing of the reasons for the delay and the date by which a decision will be made.
Distribution	Give a copy of the form to anyone requesting it. If you should receive a form, forward it to the Security and Privacy Office or give it to your facility privacy official by the end of the next working day.
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the section identifying which health information should be amended and why. The client shall identify the amendments requested.

Request to Change How Health Information Is Provided, Form 470-3947

Purpose	Clients may use form 470-3947 to request that protected health information be shared with them by alternative means, such as by e-mail or fax or at a different location, either by mail or in person.
Source	Print or photocopy this form from sample in the manual.
Completion	The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Security and Privacy Office or to the facility privacy official. The Security and Privacy Office (acting for Medicaid and Hawki) may deny this request if a reasonable explanation of why the request is being made is not received. The facility privacy official may not deny the request for that reason.
Distribution	Give a copy of the form to anyone requesting it. If you should receive a form, forward it to the Security and Privacy Office or your facility privacy official by the end of the next working day.
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the section identifying which health information should be shared differently and why and how.

Request to End an Authorization, Form 470-3949

Purpose	Clients may use form 470-3949 to request that form **470-3951** or **470-3951(S), Authorization to Obtain or Release Health Care Information** or form **470-4459, Authorization to Disclose Information to the Department of Health and Human Services** be revoked.
Source	Print or photocopy this form from sample in the manual.
Completion	The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Security and Privacy Office or to the facility privacy official.
Distribution	Give a copy of the form to anyone requesting it. If this is a request to revoke an authorization in the case file for information you have requested, file the request with the authorization and mark the authorization void to make it clear the authorization is no longer valid. If this is a request to revoke an authorization that was sent to the Security and Privacy Office for information that is not available locally, forward the authorization to the Security and Privacy Office.
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the section identifying which authorization should be revoked.

Request to Restrict Use or Disclosure of Health Information, Form 470-3953

Purpose	Clients may use form 470-3953 to request that the use or disclosure of protected health information be restricted.
Source	Print or photocopy this form from sample in the manual.
Completion	The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Security and Privacy Office or to the facility privacy official. The facility privacy official or the Security and Privacy Office, acting for Medicaid and Hawki, shall make the final decision on whether to agree to the requested restrictions.
Distribution	Give a copy of the form to anyone requesting it. If you should receive a form, forward it to the Security and Privacy Office or your facility privacy official by the end of the next working day.
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the section identifying which health information should be restricted and why. The client shall identify the restrictions requested.