Personnel-Certified/Non-Certified

Use and Disclosure of Employee Medical Information (HIPAA)

The Board of Education directs the Superintendent or his/her designee to take the necessary steps to ensure compliance with the Health Insurance Portability Act of 1996 (HIPAA). Compliance activities shall include conducting an audit to determine applicability of HIPAA to District operations, recommending policies to the Board, implementation of administrative regulations, including record keeping procedures, preparation of necessary documents, employee training and all other activities necessary to ensure compliance.

Legal Reference: 42 U.S.C. 1320d-1320d-8, P.L. 104-191, Health Insurance Portability and Accountability Act of 1996 (HIPAA)

65 Fed. Reg. 50312-50372

65 Fed. Reg. 92462-82829

63 Fed. Reg. 43242-43280

67 Fed. Reg. 53182-53273

Policy adopted: November 17, 2005

NEW LONDON PUBLIC SCHOOLS
New London, Connecticut

Policy revised: March 10, 2022

Authorization Form for Release of Health Information under HIPAA

I, _____, hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:
   _____

2. I authorize release of information to the New London Public Schools at _____(address)

3. I authorize release of health information regarding [body parts], from [insert date], forward.

4. I understand that this information will be used by the New London Public Schools in connection with employment related issues or in connection with my receipt of benefits from the New London School District.

5. Right to Revoke: I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at New London Public Schools. I understand that such a revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization and the information described on this form if I ask for it.

8. I understand that this authorization will expire six months from the date I sign it, unless I revoke it sooner.

9. I understand that no treatment, payment, enrollment or eligibility for benefits is conditioned upon receipt of this authorization.

_____ _____
Signature of Individual Date

_____ _____
Signature of Personal Representative Date

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of:

NEW LONDON PUBLIC SCHOOLS **4112.61**
New London, Connecticut **4212.61**
Form #2

Request that PHI Be Transmitted Confidentially

Today' Date: _____

Print name of individual making request: _____

I am requesting that effective (insert date) _____, the following protected health information (PHI) (specify PHI) _____ _____ be transmitted to me by the alternate means or location described below:

(Insert the new mailing address/place or manner in which individual will receive future information that would otherwise have been mailed to the individual's address on file (e.g. will personally pick up.)

_____

_____

Signature of individual requesting confidential transmission of PHI: _____

OR

Signature of Personal Representative (acting on behalf of the individual) requesting confidential transmission of PHI: _____

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of: _____

Your request for confidential communication of PHI has been:

☐ Approved

☐ Denied, for the following reason(s): _____

_____

_____

Name of Privacy Officer: _____

Signature of Privacy Officer: _____ **Date:** _____

4112.61
4212.61
Form #3

NEW LONDON PUBLIC SCHOOLS
New London, Connecticut

Request Accounting of Disclosure of Protected Health Information (PHI)

Today's Date: _____

Name of individual for whom accounting of PHI is requested: _____

Name of individual requesting accounting of PHI: _____

Address: _____

_____ **Phone:** _____

I _____ am requesting that I be provided an accounting of the disclosures of the following PHI for the above noted individual during the time period starting _____ and ending _____.

For internal use only:

The above request for an accounting of disclosures of PHI by the District has been:

☐ Approved

☐ The District needs an extension of _____ days because: _____

_____

☐ Denied, for the following reason(s): _____

_____

_____

Name of Privacy Officer: _____

Signature of Privacy Officer: _____ **Date:** _____

4112.61
4212.61
Form #4

NEW LONDON PUBLIC SCHOOLS
New London, Connecticut

Request to Amend Protected Health Information (PHI)

Today's Date: _____

Name of individual for whom PHI amendment is requested: _____

Name of individual requesting amendment of PHI: _____

Address: _____

_____ **Phone:** _____

I am requesting that an amendment be made to the following PHI: _____

_____

_____

_____

_____

For the following reason(s): _____

_____

_____

_____

_____

The above request for amendment to the above noted PHI has been:

☐ Approved

☐ Denied, for the following reason(s): _____

_____

_____

Name of Privacy Officer: _____

Signature of Privacy Officer: _____ **Date:** _____

NEW LONDON PUBLIC SCHOOLS **4112.61**
New London, Connecticut **4212.61**
Form #5

Request to Terminate the Confidential Transmission of PHI by Alternate Means/Location

Today's Date: _____

Print name of individual making request: _____

I am requesting that effective (insert date) _____, my original request to maintain confidentiality of PHI delivery by an alternate means/location be terminated. Please deliver all future PHI to me at my usual address/location as follows:

(Insert the mailing address or manner or usual place where individual will personally pick up the information.) _____

_____

_____

Signature of individual requesting confidential transmission of PHI: _____

OR

Signature of Personal Representative (acting on behalf of the individual) requesting confidential transmission of PHI: _____

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of:

_____

The above noted request to terminate confidentiality of PHI has been reviewed and:

☐ Will be adopted as requested on the date requested above.

☐ Will be adopted but with these modifications: _____

_____

☐ Can not be adopted because (*insert reasons*): _____

_____

Name of Privacy Officer: _____

Signature of Privacy Officer: _____ **Date:** _____

NEW LONDON PUBLIC SCHOOLS **4112.61**
New London, Connecticut **4212.61**
Form #6

Appointment of Personal Representative

Complete the following chart to indicate the name of the proposed Personal Representative

	Employee	Proposed Personal Representative
Name (print):		
Address (City, State, Zip):		
Phone:	( )	( )

I, _____*[Name of Participant or Beneficiary]*

hereby designate _____*[Personal Representative]:*

☐ to act on my behalf, _____

☐ to act on behalf of my spouse named: _____

☐ to act on behalf of my dependent child(ren) named: _____

I authorize my Personal Representative to act for me and for my covered spouse and dependents (if named above) in receiving the following protected health information to conduct the following functions on my behalf: _____

I understand that this designation of a Personal Representative is subject to approval by the District. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the Privacy Officer, on a form for Revocation of a Personal Representative available from the Privacy Officer.

_____ _____
Employee's Signature Date

_____ _____
Signature of Personal Representative Date

The above Personal Representative request is:

☐ approved ☐ not approved because: _____

Name of Privacy Officer: _____

Signature of Privacy Officer: _____ **Date:** _____