MARKLUND
HUMAN RESOURCES POLICY AND PROCEDURE

POLICY NO: 6.0		PAGE 1 OF 5
SUBJECT: Confidentiality and Privacy Rule (HIPAA)		
DEPARTMENTS AFFECTED: ALL		APPROVED BY:
ISSUE DATE: 6/21/93	REVISION DATES: 7/16/94; 8/9/96; 5/1/98; 3/4/05; 12/1/2016	EFFECTIVE DATE: 6/21/93

PURPOSE:
To maintain the confidentiality and privacy of persons served in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended.

POLICY:
Marklund, in accordance with federal and state laws, has developed a policy concerning all rights to confidentiality and privacy that is inherent to this right. HIPAA includes the Privacy Rule standards that address the use and disclosure of individuals' health information – referred to as Protected Health Information (PHI). PHI refers to individually identifiable health information that is transmitted by electronic media, or transmitted or maintained in any other form or medium. It is the goal of Marklund to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

PROCEDURES:
Responsibility of Staff and Others
All staff employed by Marklund, as a condition of employment, will maintain the confidentiality and privacy of the person served. This includes not only regular employees of Marklund, but also consultants, interns and volunteers providing services. Failure to maintain confidentiality and privacy may result in developmental action.

Responsibility of Marklund
Upon Orientation, after being hired by any program within Marklund, each employee will be required to read the current Marklund Confidentiality Privacy Rule Policy and to sign an agreement to adhere to it. (See Attachment 1.) This procedure will also be followed for all interns and consultants who may be exposed to confidential Client information. Registered volunteers will receive confidentiality training and sign an agreement to adhere to such practices.

Marklund will provide additional, on-going training on confidentiality and privacy issues to all Marklund employees to ensure the continued implementation of confidentiality policies.

Marklund will designate one person to assume responsibility for ensuring the confidentiality of Protected Health Information (PHI). This person will be designated as the Security Officer. All staff and individuals served or their legal guardian will receive a Notice of Privacy Practices (Attachment 2.)

Marklund's Notice of Privacy Practices will be posted on the organization's website.

Marklund will provide the technical and training resources to protect PHI from compromise.

Release of Information
No protected information may be released about a person served by telephone, in person, or in writing unless there is a written release signed by the person served or the guardian if one has been appointed. (See Attachment 3.) The consent form will specify:

1. The person or agency to whom the disclosure is to be made
2. The purpose for which the disclosure is to be made
3. The nature of the information to be disclosed
4. The right to inspect and copy the information to be disclosed
5. The consequences of a refusal to consent, if any
6. The calendar date on which the consent expires (not to exceed one (1) year)
7. The right to revoke the consent at any time

Marklund will release only the minimum necessary information for the purpose stated in the release.

Exceptions to Confidentiality
In cases in which there is a clear danger to the person served or others, and the person served and/or guardian are unable to give consent for release of information, confidentiality may be suspended. This would include but not necessarily be limited to:

- Emergency treatment at a hospital
- Notifying police or appropriate agencies for a missing person
- Notifying state department representatives (DCFS, DOA, DPH, OIG) or other appropriate agencies in suspected abuse cases
- Other circumstances where the safety of the individual or others is at risk

When an agency which provides services is being reviewed for purposes of funding, accreditation, reimbursement or audit by a state or federal agency or accrediting body, the record of the person served may be used by the surveyor and personally identifiable information may be disclosed without consent, provided that it is necessary to accomplish the purpose of the review.

For the purposes of statistical compilation, research, evaluation or other similar purpose, information will not be disclosed unless the person who consents to the disclosure specifically consents to the re-disclosure of the information.

Confidentiality regarding Faxes
Any confidential information regarding persons served that is faxed to another location will be accompanied with a cover sheet containing a Confidentiality Statement and reference to HIPAA (Attachment 4.)

Confidentiality regarding Tours and Visitors
Periodically, tours of Marklund programs are given to prospective service recipients and community members for the purpose of program observation, education, and public relations. Because of the mandated rights to confidentiality and privacy, all visitors will be informed regarding privacy and confidentiality at the beginning of each tour by the person conducting the tour. Tour groups will be accompanied by a staff member at all times.

Only first names of persons served may be given to tour members and persons served will be discussed only in very general forms. All tour members will be informed of Marklund's expectation that they will not divulge any personal or identifying information obtained inadvertently during the tour or observation.

Confidentiality regarding use of Photographs

Occasionally, photographs are taken of individuals or families participating in the programs at Marklund. Upon admission to the program, the person served or his/her guardian, if appointed, will be asked to sign a photo release stating whether or not the person will agree to be photographed. (See Attachment 5.)

Persons served or their guardians have the right to refuse permission for photos to be taken or to revoke consent by submitting the revocation in writing.

Inspection of Records

Persons served or their guardians have the right to inspect any information contained within their files and to have it photocopied. If copies are required, a written request must be filled out (see Attachment 6) and a fee of $0.50 per page may be assessed on a case-by-case basis at the discretion of the Administrator and payable prior to distribution of records.

Only individuals specified on the Authorization for restricted access to psychotherapy notes will be allowed access to those records (see Attachment 7).

If the person or guardian asks for modification of the record because they believe the information is inaccurate or misleading, they are entitled to submit a written statement about any disputed or new information. This statement must be entered into the record. This addendum must be disclosed whenever the questioned portion of the record is disclosed.

If a person believes that their record contains inaccurate or incomplete Protected Health Information (PHI) a request for amendment can be made. This is done by contacting the Medical Records Coordinator and requesting a Request to Amend Health Information Form (Attachment 8).

Whenever access or modification is requested, a note should be made in the record of the request and any actions taken.

Access to Records

Staff, Consultants and Interns

Besides the person served and/or his guardian, access to confidential records will be limited to Marklund staff, consultants, and interns hired to provide services to that individual. These persons will have access only to those portions of information necessary to provide effective responsive services to individuals.

Human Rights/Behavior Management Committee

Because the Human Rights/Behavior Management Committee includes persons who are not affiliated with Marklund and because the function of this committee is to ensure the rights of each person served are not violated, access to records is permissible only when a rights/behavior management issue is being reviewed. All committee members who are not Marklund employees will be required to sign a Business Associate Contract (Attachment 9) and to maintain privacy and confidentiality under HIPAA.

Volunteers
No personal information will be given to volunteers regarding persons served without the specific consent of the individual/guardian. Information regarding medical conditions or behavioral problems may be given to volunteers on a case specific basis at the discretion of the director of the program or designated program staff when that information disclosure may be necessary to ensure the safety of the person served and/or the volunteer.

Ensuring Confidentiality and Privacy within Records and Conversations
Records
Entries in an individual's record referring to actions with another individual will be worded in such a way as to protect the confidentiality of the persons served. At no time will the name of a person served be put on any report, document, or note which will be placed in the file of another person served. This would include progress notes, incident reports and data sheets.

Signs or notices regarding individuals served will not use last names and will be placed in a location which is not easily observable to visitors.

Conversations
Staff will be cautious in discussing persons served with anyone not entitled to information regarding the person. This includes, but is not limited to, conversations with parents, other persons served or persons in the community not connected to Marklund. Whenever it is necessary to discuss persons served with others, staff will ensure that the identity of the person served is protected. Marklund staff will also be discreet when discussing persons served with other Marklund staff when such conversations occur in a public place, e.g., a restaurant.

Safekeeping of Records
Marklund accepts responsibility for the safekeeping of each individual's record and for securing it against loss, destruction, or access by unauthorized persons.

In order to safeguard these records, all files will be kept in areas inaccessible to persons other than those authorized to use the files. Information such as behavior management programs, reports of unusual incidents and data sheets will be kept in a locked cabinet or in an area not easily accessible to unauthorized persons.

All documents containing information about persons served will be kept in a location which is not easily observable to visitors or other employees not entitled to the information.

Retention of Records
The Medical Records Coordinator is responsible for purging the oldest material for the active medical personal) charts. Oldest material is hereby defined as being four (4) months old in charts of persons served. Doctor's progress notes are kept for one (1) year in the active chart. All lab reports or miscellaneous medical records are left in the personal chart at the discretion of the Director of Nursing or Nurse Manager. Any Active Treatment, i.e.: IPP's, QIDP notes and assessments are also left in the charts for one (1) year at the discretion of the QIDP.

If a person served is discharged prior to his/her 18th birthday, their medical records will be placed in an inactive file until the client reaches, or would have reached, the age of 23. If a person served is discharged when he/she is 18 or older, the medical records will be maintained in an inactive file for five

(5) years following the date of discharge.

Destruction of confidential information which contains PHI of a person served will be overseen by the Medical Records Coordinator, and must be destroyed in a manner that prevents reconstruction:

- *Paper/materials records*: shredding, burning, pulping or pulverizing so that PHI is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed
- *PHI on electronic media*: clearing (using software or hardware products to overwrite media with non-sensitive data), purging (degaussing or exposing media to a strong magnetic field in order to disrupt the recorded magnetic domains), or destroying the media (disintegration, pulverization, melting, incinerating, or shredding)

Removal of Records
At no time will the records/files of persons served be removed from Marklund premises except with the permission of the appropriate Director, or by court order or subpoena.

CONFIDENTIALITY / PRIVACY RULE (HIPAA)

Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

"There are three major purposes included in the regulation regarding confidentiality and privacy: (1) to protect and enhance the rights of consumers by providing them with access to their health information and controlling the inappropriate use of information; (2) to improve the quality of health care in the U.S. by restoring trust in the health care system among consumers, health care professionals, and the multitude of organizations and individuals committed to the delivery of care; and (3) to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individuals."

December 2000 preamble

What does HIPAA do?

- Protects the privacy of a client's personal and health information
- Provides for electronic and physical security of personal and health information
- Simplifies billing and other transactions
- Provides a process for individuals to make complaints and document such complaints and their disposition.

HIPAA and confidentiality regulations have been explained to me and I have read and understand how they apply to clients, clients' health records and history, and employment and volunteer records.

I also understand that failure to follow HIPAA and confidentiality regulations may result in termination/separation from Marklund, as well as criminal prosecution, and that I may be fined amounts varying from $100.00 per violation for minor offenses up to $50,000 per violation with an annual maximum of $1.5 million and/or imprisonment for major violations.

I have read and understand HR Policy NO. 6.0.

Signature *Date*

Printed Name

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

I. OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

We are committed to preserving the privacy and confidentiality of your health information or the health information of your family member, whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of health information. Copies of our privacy policies and procedures are maintained in the business office. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Individually identifiable information about your past, present, or future health or condition, the provisions of health care to you, or payment for the health care treatment, or services you receive is considered *protected health information (PHI).* We are required to provide you with this *Privacy Notice* that contains information regarding our privacy practices that explains how, when and why we may use or disclose your protected health information and your rights and our obligations regarding any such uses or disclosures.

Should you have questions concerning our Privacy Notices, the names, addresses, telephone numbers, website addresses, etc., of whom you should contact see the list on the last page of this document.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We have a limited right to use and/or disclose your health information for purposes of treatment, payment, or for the operations of our facility. For other uses, you must give us your written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization.

Should it become necessary to release your protected health information to an outside party, we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have included examples of the different types of uses or disclosures.

These include:

1. **Use and Disclosures Related to Treatment:**
   We may disclose your protected health information to those who are involved in providing medical and nursing care services and treatments to you. For example, we may identify rooms by medical and nursing care services and treatments to you. For example, we may identify rooms by the first name and last initial of the occupant, or release health information about you to our nurses, nursing assistants, medication aides/technicians, medical and nursing students, therapists, pharmacists, medical records personnel, consultants, physicians, etc. We may also disclose your protected health information to outside entities performing other services relating to your treatment; such as diagnostic laboratories, home health/hospice agencies, family members, etc.

2. **Use and Disclosures Related to Payment:**
   We may use or disclose your protected health information to bill and collect payment for services or treatments we provided to you. For example, we may contact your insurance facility, health plan, or another third party to obtain payment for services we provided to you.

III. <u>USES AND DISCLOSURES OF INFORMATION THAT DO NOT REQUIRE YOUR CONSENT OR AUTHORIZATION</u>

State and Federal law and regulations either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization include the following:

1. **When Required by Law:**
   We may disclose your protected health information with a federal, state or local law requires that we report information about suspected abuse, neglect, or domestic violence, reporting adverse reactions to medications or injury from a health care product, or in response to a court order or subpoena.

2. **For Public Health Activities for the Purpose of Preventing or Controlling Disease, Injury or Disability:**
   We may disclose your protected health information when we are required to collect information about disease or injuries (e.g., your exposure to a disease or your risk for spreading or contracting a communicable disease or condition, product recall, or to report vital statistics (e.g., births/deaths) to the public health authority.

3. **For Health Oversight Activities:**
   We may disclose your protected health information to a health oversight agency such as a protection and advocacy agency, that state agency responsible for inspecting our facility or to other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with the applicable state and federal laws and regulation and civil rights issues.

4. **To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks:**
   We may disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We may also disclose your health information to a funeral director for the purposes of carrying out your wishes and/or for the funeral director to perform his/her necessary duties.

   If you are an organ donor, we may disclose your protected health information to the organization that will handle your organ, eye or tissue donation for the purposes of facilitation your organ or tissue donation or transplantation.

5. **For Research Purposes:**
   We may disclose your protected health information for research purposes only when a privacy board has approved the research project. However, we may use or disclose your protected health information to individuals preparing to conduct an approved research project in order to assist such individuals in identifying persons to be included in the research project. Researches identifying person to be included in the research project will be required to conduct all activities onsite. If it becomes necessary to use or disclose information about you that could be used to identify you by name, we will obtain your written authorization before permitting the researcher to use your information. Researchers will be required to sign a *Confidentiality and Non- Disclosure Agreement* form before being permitted access to health information for research purposes.

6. **To Avert a Serious Threat to Health or Safety:**
   We may disclose your protected health information to avoid a serious threat to your health or safety or to the health or safety of others. When such disclosure is necessary, information will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.

7. **For Specific Government Functions:**
   We may disclose protected health information of military personnel and veterans, when requested by military command authorities, to authorized federal authorities for the purposes of intelligence, counterintelligence, and other national security activities (such as protection of the President), or to correctional institutions.

8. **For Fund-raising:**
   We may use a limited amount of your protected health information when raising money for our facility and its operations. We may also disclose this information to a foundation related to the facility so that the foundation may contact you to raise money on behalf of our facility. The information we may use will be limited to your name, address, telephone number, photograph, and dates for which you received treatment or services at our facility. Tours of the facility may take place from time to time. We may have these individuals meet you. You may be photographed during special events such as Summer Games, Holiday Open House, etc. Occasionally, there may be media coverage. If you do not wish to be

contacted for participation in fund-raising activities or have this information provided to our affiliated foundation, you must provide us with a written notification. The name of the person to contact and the method of contacting him/her are listed on the last page of this notice.

IV. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights concerning the use of disclosure of your protected health information that we create or that we may maintain on our premises.

1. **To Request Restriction on Uses and Disclosures of Your Protected Health Information:**
   You have the right to request that we limit how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care of the payment of or your care or services. For example, you could request that we not disclose to family members or friend's information about a medical treatment you received.
   Should you wish a restriction placed on the use and disclosure of your protected health information, you must submit such request in writing. The name, address, and telephone number of the person to whom the request is to be submitted is listed on the last page of this document.

   We are not required to agree to your restriction request. However, should we agree, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you.

2. **The Right to Inspect and Copy Your Medical and Billing Records:**
   You have the right to inspect and copy your health information, such as your medical and billing records that we use to make decisions about your care and services. In order to inspect and/or copy your health information you must submit a written request to us. If you request a copy of your medical information, we may charge you a reasonable fee for the paper, labor, mailing, and/or retrieval costs involved in filing your request. We will provide you with information concerning the cost of copying your health information prior to performing such service. The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. We will respond within thirty (30) days of receipt of such requests. Should we deny your request to inspect and/or copy your health information, we will provide you with written notice of our reasons of the denial and your rights for requesting a review of our denial. If such review is granted or is required by law, we will select a licensed health care professional not involved in the original denial process to review your request and our reason for denial. We will abide by the reviewer's decision concerning your inspection/copy requests. You may submit your denial review requests in writing.

3. **The Right to Amend or Correct Your Health Information:**
   You have the right to request that your health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You

have the right to make such request of us for as long as we maintain/retain your health information. Your request must be submitted to us in writing. We will respond within sixty (60) days of receiving the written request. If we approve your request, we will make such amendments/corrections and notify those with a need to know of such amendments/corrections.

We may deny your request if:

a. Your request is not submitted in writing
b. Your written request does not contain a reason to support your request
c. The information was not created by us, unless the person or entity that related the information is no longer available to make that amendment
d. It is not part of the health information kept by our facility
e. It is not part of the information which you would be permitted to inspect and copy, and/or
f. The information is already accurate and complete

If your request is denied, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response you may have relative to the information and denial process appended to your health information. The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document.

4. The Right to Request Confidential Communication:

You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you may request that we not send any health information about you to a family member's address. We will agree to your request, as long as it is reasonably easy for us to do so. You are not required to reveal nor will we ask the reason for your request.

To request confidential communications, you must:

a. Notify us in writing;
b. Indicate what information you wish to limit;
c. Indicate whether or not you wish to limit or restrict our use of disclosure of such information; and
d. Identify to whom the restrictions apply (e.g., which family member(s), agency, etc.).

The name, address and telephone number of the person to whom you may file your request is listed on the last page of this document.

5. The Right to Request an Accounting of Disclosures of Protected Health Information:

You have the right to request that we provide you with a listing of when, to whom, for what purpose, and what content of your protected health information we have released over a specified period of time. This accounting will not include any information we have made for the purposes of treatment, payment, or health care operations or information released to you, your family, or the facility directory,

disclosures made for the national security purposes, or any release pursuant to your authorization.

Your request must be submitted in writing and must indicate the time period for which you wish the information (e.g., May 1, 2003 through August 31, 2005). Your Request may not include release for more than six (6) years prior to the date of your request and may not include releases prior to April 14, 2003. Your request must indicate in what form (e.g., printed copy or E-mail) you wish to receive this information. We will respond to your request within sixty (60) days of the receipt of your written request. Should additional time be needed to reply, you will be notified of such extension. However, in no case will such extension exceed thirty (30) days. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional request during the twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document.

6. The Right to Receive a Paper Copy of This Notice:
You have the right to receive a paper copy of this notice even though you may have agreed to receive an electronic copy of this notice. You may request a paper copy of this notice at any time or you may obtain a copy of this information from our website (as applicable). The name, address, and telephone number of the person to whom you may obtain a paper copy of this notice is listed on the last page of this document.

V. HOW TO FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you have reason to believe that we have violated your privacy rights, violated our privacy policies and procedures, or you disagree with a decision we made concerning access to your protected health information, etc., you have the right to file a complaint with us or the Secretary of the Department of Health and Human Services. Complaints may be filed without fear of retaliation in any form.

To ask questions, request information or to file a complaint with us, contact us by phone or by mail:

Our Designee: Wendy Berk, Security Officer
1 S 450 Wyatt Drive
Geneva, IL 60134
Telephone: (630) 593-5500

To file a complaint with the United States Secretary of Health and Human Services, send your complaint to him\her in care of:

Office of Civil Rights
U.S. Department of Health and Family Services
200 Independence Ave, SW
Washington, D.C. 20201

By my/our signature below I/we acknowledge that I/we have been informed, fully understand and have received a copy of the "Notice of Privacy Practices."

____

Signature of individual or Authorized Representative Date

____

Print Name

____

Name of Client

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize____ to release

(facility/physician/therapist)

(state specific nature of information to be disclosed)

about ____

(Client's name)

(receiving agency/person)

(address)

for the purpose of ____
____
____

This consent is valid until ____

I understand that I may revoke this consent at any time and that the above-named person who is authorized to receive information has the right to inspect and copy the information to be disclosed. It has been explained to me that if I refuse consent to this release of information the following are the consequences:

(Specify, if any):____
____
____
____

______________________________	______________________________
(witness)	(signature)
______________________________	______________________________
(date)	(date)

____
If signature is not of Client, indicate legal relationship to client and basis on which consent is given.

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentially Act, you may not redisclose any of this information unless the person who consented to the disclosure specifically consents to such redisclosure.

Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records or information from such records may be further disclosed without specific authorization for such redisclosure.

Marklund at Mill Creek
1S450 Wyatt Drive
Geneva, IL 60134
630.593.5500 Phone

CONFIDENTIAL HIPAA
FACSIMILE TRANSMITTAL COVER SHEET

DATE: ____________________

TO: ________________________________ FAX: ______________________________

FROM: ______________________________ FAX: _______**630-593-5501**_______

OF PAGES: ____________________

SUBJECT: ____

COMMENTS:____
____
____
____
____

The information contained in this facsimile message is confidential, some or all of which may be protected health information as defined by the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. It is intended for the use of the addressee listed above. If you are neither the intended recipient nor an employee of the addressed organization charged with delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action reliant on the content of this telecopied information is a violation of Illinois Law, and it is strictly prohibited. If you have received information in error, please notify the person sending the information and return to them via: U.S. Postal Service to the address listed below:

Marklund Administration
1S450 Wyatt Drive
Geneva, IL 60134
c/o HIPAA Security Officer

CONSENT TO BE PHOTOGRAPHED

For good and valuable consideration, the receipt of which I hereby acknowledged, I or my legal representative if I am unable to do so, hereby authorize Marklund, its legal representatives, successors and assigns, and all persons or corporations acting with its permission or upon its authority, the absolute rights and unrestricted permission to copyright, use and/or publish photographic portraits or pictures of my child/ward, (still, single, multiple or moving), in which my child/ward may be included in whole or in part, or reproductions of these photographs, in color or otherwise made through any media, including social media sites (i.e. Facebook, Twitter) for the purpose of advertising, publicity, and fundraising for the benefit of Marklund.

I also give permission for my child/ward to be identified by first name last initial.

I waive any right that I may have to inspect and approve the finished product or the use of which it may be aplied, which includes advertising, publicity and fund-raising for the benefit of Marklund.

I release and agree to hold harmless Marklund, its directors, agents, employees, successors and assigns from any and all claims, liability, loss or expenses, including reasonable attorney's fees, which may result from the taking and use of photographs.

I understand that this consent is valid until revoked by the parent or guardian. I understand that I may revoke this consent at any time upon written request.

____
Name of your Child/Ward

____
Signature of Parent/Legal Guardian/Representative Date

____
Print- Parent/Legal Guardian/Representative

____
Signature of Witness Date

____
Print- Witness

❑ **I DO NOT CONSENT**

____
Signature of Parent/Legal Guardian/Representative Date

____
Print- Parent/Legal Guardian/Representative

MARKLUND
MEDICAL RECORDS REQUEST

DATE: ____________________________ FACILITY: _________________________

CLIENT'S NAME: ____

REQUESTED BY: ____

DEPARTMENT: ____

RECORDS REQUESTED:

____

____

____

____

____

ADDITIONAL INSTRUCTIONS (IF ANY):

____

____

____

____

SIGNATURE OF PERSON RELEASING RECORDS: ________________________

SIGNATURE OF PERSON RECEIVING RECORDS: ________________________

UPON RECEIPT OF THE RECORDS, ______________________SCHOOL FILE IS COMPLETE: ________________________________

Filled by: _________________________ Date: _____________________
Start time: _________________________ End time: __________________

Authorization for Restricted Access to Psychotherapy Notes

I, _________________________ Parent/Guardian of ________________

hereby give permission to the following individuals to read any and all psychotherapy notes solely for the purpose of providing appropriate treatment and care: Q.I.D.P., Medical Director, Social Services, Administrator, Director of Adult Services, Director of Children's Services, Director of Education, Director of Nursing and Nurse Manager.

Signature ___________________________

Printed Name ___________________________

Date ___________________________

This document is valid for a period of one year and will be renewed December 1st of each year.

Request to Amend Health Information

Client Name: ______________________________________ Date: ____________

Date of Birth: _________________________

Client's Address:

____

Describe the information you want amended:

____
____
____

Date(s) of information you want amended:

____

What is your reason for making this request?

____
____
____

Describe how the entry is incorrect, incomplete, or outdated:

____
____
____

What should the entry say to be more complete or accurate?

____
____
____

Do you know of anyone who may have received or relied on the information in question?
___Yes ___No
If yes, please specify the name(s) and address(es) of the organization or individual(s):

____
____

____ _______________________
Client/Guardian or Authorized Representative Signature Date

For Practice Use Only

Amendment has been: __________ Accepted __________Denied

If denied, check the reason for denial:

- ☐ PHI was not created by Marklund
- ☐ PHI is not part of the client's record
- ☐ PHI is accurate and complete

Staff comments:

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Staff Signature: ____ Date: _____________

Print name and title:

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HIPAA BUSINESS ASSOCIATE AGREEMENT

This Agreement ("Agreement") is effective on _______________, and is between MARKLUND CHILDREN'S HOME, INC., an Illinois not-for-profit corporation, ("Care Provider") and __________________________, ("Associate").

Care Provider and Associate agree to this Agreement in order to comply with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in 45 CFR, Parts 160-164. In the event of conflicting terms or conditions, this Agreement shall supersede any definition.

1. BACKGROUND

a) Care Provider is subject to and must comply with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in 45 CFR, Parts 160-164;

b) Associate constitutes an "Associate" of Care Provider (as such term is defined in the Regulations) and wishes to commence or continue its business relationship with Care Provider as provided for in the past;

c) Associate acknowledges that Care Provider must comply with the Regulations and that to achieve such compliance the written agreement between Care Provider and Associate must contain certain satisfactory assurances that Associate will appropriately safeguard certain protected health information, "PHI", which it receives from, or creates or receives on behalf of Care Provider (as such term is defined in the Regulations);

d) Care Provider needs the assistance of Associate, and Associate wishes to assist Care Provider in achieving and maintaining such required compliance with the Regulations; and

e) By this Agreement, Care Provider and Associate wish to include provisions as required by the Regulations and bring the business relationship between the Parties into compliance therewith.

2. USES AND DISCLOSURES OF INFORMATION

Associate shall use and/or disclose PHI only to the extent necessary to satisfy Associate's obligations. Associate shall not use or disclose any PHI received from or on behalf of Care Provider, except as permitted or required by these obligations or as otherwise authorized in

writing by Care Provider. Associate shall comply with: (a) Title 45 Part 164 of the CFR as if Associate were a Care Provider; and (b) State laws, rules and regulations applicable to PHI not preempted pursuant to Title 45, Part 160, Subpart B of the CFR.

a) Business Associate's Operations.

Associate may use PHI it creates or receives for or from Care Provider only to the extent necessary for Associate's proper management and administration or to carry out Associate's legal responsibilities. Associate may disclose such PHI as necessary for Associate's proper management and administration or to carry out Associate's legal responsibilities only if the disclosure is required by law. Associate shall ensure that any agents, including but not limited to subcontractors, to whom it provides PHI agree to the same restrictions and conditions as apply to Associate with respect to such PHI.

b) Subcontractors and Agents.

Associate shall, and shall cause its agents (including, but not limited to, its subcontractors) to at all times adhere to all material terms and in no way breach or violate any material term of the Agreement that pertains in any way, directly or indirectly, to PHI or the protection of the confidentiality thereof.

c) Accommodation of Individual Rights.

Associate shall make PHI available and provide individuals with access to inspect and obtain a copy of such PHI of which each such individual is the subject in accordance with the Regulation. Associate shall make available PHI for amendment and incorporate any amendments to PHI in accordance with the Regulations. Associate shall make available PHI required to provide an accounting of disclosures to an individual in accordance with the Regulations.

d) Accounting to Care Provider and to Government Agencies.

Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from or on behalf of Care Provider available to Care Provider and to the Secretary of the United States Department of Health and Human Services or its designee for the purpose of determining compliance with the provisions of Title 45, Parts 160 and 164 of the CFR.

e) Health Information Safeguards.

Associate shall develop, implement, maintain and use appropriate administrative, technical and physical safeguards to prevent the improper use or disclosure of any PHI received from or on behalf of Care Provider.

f) Electronic Health Information Security and Integrity.

Associate shall develop, implement, maintain and use appropriate administrative, technical and physical security measures in compliance with Title 45, Part 142 of the CFR to preserve the integrity and confidentiality of all electronically maintained or transmitted Health Information received from or on behalf of Care Provider pertaining to an Individual. Associate shall document and keep these security measures current.

g) Reporting.

Associate agrees to comply with all statutory requirements governing the maintenance of documentation, to verify the cost of services rendered under this Agreement. Associate shall report to Care Provider any use or disclosure of the Individually Identified Health Information not authorized by this Agreement or in writing by Care Provider. Associate shall make the report to Care Provider's Privacy Official not less than 24 hours after Associate learns of such unauthorized use or disclosure. Associate's report shall at least: (a) identify the nature of the unauthorized use or disclosure; (b) identify the PHI used or disclosed; (c) identify who made the unauthorized use or received the unauthorized disclosure; (d) identify what Associate has done or shall do to mitigate any deleterious effect of the unauthorized use or disclosure; (e) identify what corrective action Associate has taken or shall take to prevent future similar unauthorized use or disclosure; and (f) provide such other information, including a written report, as reasonably requested by Care Provider's Privacy Official. Care Provider may at any time it deems appropriate, in its sole discretion, intervene, direct and control such efforts of mitigation and cooperation by Associate. Associate acknowledges such right of Care Provider to intervene, though any such intervention shall in no event or manner reduce or limit Associates obligations hereunder.

h) Services and Compensation.

Associate warrants that s/he has all the necessary qualifications, certifications, and/or licenses pursuant to current Federal and state law and regulations to provide the services required under this Agreement. Associate further warrants that s/he is not excluded from any state or federal health care program or any third-party payer program, has not been excluded from any such program, and that no basis exists for such exclusion. Associate also warrants that s/he has not been subject to any final adverse action as defined under the Health Care Fraud and Abuse Data Collection Program.

Associate agrees to notify Care Provider within twenty-four (24) hours, by certified mail/special carrier if:

i. A final adverse action is taken or threatened against the Associate;

ii. The same or substantially similar services provided to any other Associate client is the subject of inquiry or investigation by any governmental agency, intermediary, or other third-party payor;

iii. Any adverse action is taken against any other Associate client in connection with substantially similar services or billed services;

iv. A breach of confidentiality or release of protected health information is determined to have been made by Associate's employee(s), subcontractor or agent(s);

v. Suspected fraudulent billings have been made or kickbacks have been provided to employees or agents of the Care Provider; and

vi. Associate no longer maintains the necessary qualifications, certifications and/or license to provide the services as required under this Agreement.

3. DUTIES UPON TERMINATION.

Upon termination, cancellation, expiration or other conclusion of this Agreement, Associate, if feasible, shall return to Care Provider or destroy all PHI and all Health Information, in whatever form or medium (including in any electronic media under Associate's custody or control), that Associate received from or on behalf of care Provider, including any copies of and any Health Information or compilations derived from and allowing identification of such PHI or such Health Information. Associate shall complete such return or destruction as promptly as possible, but not later than 30 days after the effective date of the termination, cancellation, expiration or other conclusion of this Agreement. Within such 30-day period, Associate shall certify on oath in writing to Care Provider that such return or destruction has been completed or, if return or destruction is not feasible written justification explaining why such PHI could not be returned or destroyed.

a) Representations and Warranties.

Associate represents and warrants to Care Provider, upon execution and throughout the Term of this Agreement as follows:

i. Associate has, and shall maintain throughout the Term, all appropriate federal and state licenses and certifications which are required in order for Associate to perform the Services required of him or her under this Agreement and to receive reimbursement for said Services;

ii. Associate's personnel, if any, are each in full compliance with all pertinent federal and state requirements, including but not limited to, immigration, licensing, certification, health and immunizations status in order to

perform the functions assigned to him or her in connection with Associate's obligations under this Agreement.

iii. Associate certifies, by entering into this Agreement, that neither s/he, his/her principals, employees, nor independent contractors, if any, are presently under investigation for wrongdoing, nor debarred, suspended, declared ineligible, voluntarily or involuntarily excluded from participation in health care reimbursement programs by any state or federal department or agency.

iv. Associate agrees to provide to Care Provider immediate notice and explanatory information as it develops, of any change of circumstance relative to this certification.

v. Associate certifies that s/he does not have a direct or indirect financial relationship with any of its subcontractors, business associates, etc. or the Care Provider that precludes the Associate from providing services/supplies in accordance with current regulations governing referrals and kickbacks.

vi. Associate understands that this certification is a necessary condition for the continuation of this Agreement.

b) Compliance with Laws.

Associate shall, and shall cause its agents (including, but not limited to, its subcontractors) to at all times comply and allow and enable Care Provider to comply, with all applicable laws and regulations, including but not limited to, the Regulations.

4. LIMITATION OF LIABILITY

The limitation of liability governing this Agreement shall be as set forth in this Agreement, except that the indemnification provisions of Section 5 herein shall in no event be subject to any limitation of liability or damages set forth in the Agreement, and no express or implied agreement or arrangement between the parties shall in any way reduce or limit Associate's liability therefor.

5. INDEMNIFICATION

Associate shall defend, indemnify and hold harmless Care Provider, its officers, directors, employees and volunteers, from and against any claims and shall pay all losses, damages, liabilities, claims and actions, and all related expenses (including reasonable attorneys' fees and expenses) based on or arising out of: (i) any breach or alleged breach by Associate or any agent of Associate (including but not limited to subcontractors) of any duty or obligation of the Agreement that pertains

in any way, directly or indirectly, to PHI or the protection of the confidentiality thereof; (ii) any violation or alleged violation by Associate or any agent of Associate (including, but not limited to subcontractors) of any applicable law or regulation, including but not limited to the Regulations; or (iii) any mitigation of harmful effects of a use or disclosure of PHI made by Associate or any agent of Associate (including, but not limited to subcontractors) in material breach of any duty or obligation under the Agreement or in violation of any applicable law or regulation, including but not limited to the Regulations.

6. RIGHT TO TERMINATE FOR BREACH.

Notwithstanding anything to the contrary in the Agreement, Care Provider shall have the right to immediately terminate the Agreement without penalty or additional fee, and Associate shall not refuse to authorize or recognize any such termination, if Care Provider shall, in its sole discretion, determine that Associate has violated or breached a material term of the Agreement, as pertains, directly or indirectly, to the use and disclosure of PHI. Associate shall reasonably cooperate in, and provide any requested services to facilitate, Care Provider's transition to another service provider following any such termination. This Agreement shall take effect as of the Effective Date defined below.

7. CONFIDENTIALITY, USE AND RELEASE OF PROTECTED HEALTH INFORMATION.

Associate and Care Provider agree that the terms of this Agreement shall be kept confidential. In addition, Associate agrees not to disclose any of the Care Provider's proprietary information to any other party, including the Care Provider's competitors, without the Care Provider's written consent:

Associate agrees to:

a) Use protected health information only for the purpose of fulfilling the service requirements of this Agreement;

b) To prohibit the use or disclosure of protected health information in any way that would violate current privacy standards;

c) Establish appropriate safeguards to prevent the use or disclosure of protected health information stored or maintained by the Associate whether in written or electronic form;

d) Report any misuse or disclosure of protected health information to the Care Provider and to the affected resident(s) within twenty-four (24) hours of discovering such misuse or disclosure;

e) Require its subcontractors or agents to which it provides protected health information to agree to the same restrictions and standards of the Associate as set forth in this Agreement;

f) Provide a written procedure to the Care Provider under which residents who are subjects of the protected health information may inspect and copy their information in possession of the Associate and allowing for the correction and amendment of information upon notice thereof from the Care Provider;

g) Provide a written procedure to the Care Provider under which residents will be notified of the release of protected health information as required by current HIPAA regulations; and

h) Upon expiration of this Agreement, return or destroy all protected health information received from Care Provider during the term of this Agreement, whether written or electronic format, and to retain no copies of such information. This shall not preclude the Associate from maintaining sufficient information solely to permit timely billing and to meet record retention requirements, provided that such information is returned or destroyed once such billing or record retention requirements are met and provided that the protections of HIPAA and this Agreement are extended until such time as such information is returned or destroyed.

8. AUTOMATIC AMENDMENT

Upon the effective date of any amendment to the regulations promulgated by HHS with respect to PHI, this Agreement shall automatically amend such that the obligations imposed on Associate as an Associate remain in compliance with such regulations.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf effective as of

CARE PROVIDER	ASSOCIATE
By: ______________________	By: ______________________
Print Name: Gil Fonger	Print Name: ______________________
Title: President and CEO	Title: ______________________
Date: ______________________	Date: ______________________

For questions regarding HIPAA compliance, please contact Wendy Berk, Security Officer for Marklund at 630-593-5500, extension 5433.