Spelman College HIPPA Privacy Rule: Authorization Policy and Procedures

Spelman College, in an effort to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA) maintains that employee benefits information must be kept private and confidential. We have created the following procedures to give you an overview regarding how the information is used and how the information is safeguarded.

Authorization

A valid authorization form will be required to assist with information as it relates to eligibility, claim, precertification, and other information. All documentation will be maintained for a period of six years.

1. An authorization form can be accessed from the College website or you may pick up a copy from the Office of Human Resources.
2. The completed authorization form can be either faxed to the attention of the Stacy Holloway, Privacy Officer at 404-270-5099 or brought over to Human Resources.

Spelman will not use or disclose your confidential information for any purpose other than the purpose described in our Privacy Notice, without your written authorization. You may revoke an authorization that you previously have given by sending a written request to the Privacy Officer.

CHANGES TO OUR POLICY

Spelman College may make changes to the privacy procedures at any time. If we do so, we will post those changes on our Website so you are always aware of what information has changed.

ADDRESSING PRIVACY CONCERNS

The unauthorized access, use, or disclosure of health information that contained any Spelman College health record may result in the responsible employee receiving disciplinary action up to and including employment termination. This extends to the unauthorized use or disclosure of health information that is learned, overheard during the course of business, or secured by any Spelman College employee by virtue of their employment with the College.

Departments or individuals that become aware of the unauthorized use or disclosure of protected health information that causes or reasonably could cause harm should immediately report the incident to the College privacy officer. To the

extent practicable, Spelman College will attempt to minimize the known harmful effects and/or correct known instances of harm.

If you have any questions about your privacy rights, do not understand your privacy rights, are concerned that your rights have been violated, please contact one of the following:

Spelman College
Office of Human Resources
350 Spelman Ln Box 1133
Atlanta, GA 30314
Telephone Number 404-270-5092

Fax Number 404-270-5099

CIGNA Healthcare
Privacy Office
PO Box 5400
Scranton, PA 18503
Telephone Number: 800-762-9940

Fax Number: 860-226-9513

You may also file written complaint with the Secretary of the U.S. Department of Health and Human Services. Neither Spelman College nor our healthcare provider will take any action against you if you file a complaint.

SPELMAN COLLEGE HIPAA PRIVACY AUTHORIZATION FORM

I. INFORMATION ABOUT THE USE OR DISCLOSURE

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Individual's name:______________________________ Social Security:_______________

Persons/organizations authorized to provide the information:________________________
____

Persons/organizations authorized to receive the information:________________________
____

Specific description of information to be used or disclosed (including date(s)):_________
____

Specific purpose of the disclosure:____
____

Will the Plan receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

No__________Yes (describe)____

This authorization will expire _________________________ (indicate date, or an event relating to you personally or to the purpose of the authorization (e.g., upon the resolution of my claim for benefits).

II. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.
- This Agreement is subject to the Plan's privacy policy as described in the privacy notice that the Plan's insurer previously delivered to you. If you would like another copy of the privacy notice, please contact the Plan's insurer.

____ ____________________
Signature of individual or individual's representative **Date**
(Form MUST be completed before signing.)

Printed name of the individual's personal representative:___________________________

Relationship to the individual, including authority for status as representative:__________

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

[Please make and copy of the completed authorization and give it to the Privacy Officer].