Part I - Request for Accounting of Non-Routine Disclosures of Personal Health Plan Information

Form Received By _____ Date _____

You have the right to a list of certain disclosures the Everett School Employee Benefit Trust (the "Plan") has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations as described in more detail in the Plan's Privacy Notice.

1. Employee Name:	**1a. Employee Health Plan ID Number:**
1b. Employee Date of Birth:	
2. Name of Person Whose Accounting You Are Requesting:	**2a. Relationship to Employee:** Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name:	**3a. Your Relationship to Person in Box 2:** Self ☐ Spouse ☐ Parent ☐ Child ☐ ☐ **Other (please describe relationship):**
4. Mailing Address for Records:	**4a. City, State, Zip Code:**

I understand that I can request an accounting of non-routine disclosures of personal health plan information once within any twelve (12)-month period, free of charge. If I request accountings more frequently, I understand the Plan will charge me a reasonable, cost-based fee for each subsequent request.

The accounting of non-routines disclosures of PHI will include the following information:

- The date of disclosure;
- The name of the person or entity to whom information was made and the person's or entity's address (if known);
- A brief description of the information disclosed; and
- The reason for the disclosure.

I hereby request an accounting of any non-routine disclosures of personal health plan information of the person named in Box 2 made by the Plan for the following time period _____ [Enter time period (disclosures can be requested for a time period of up six (6) years, beginning no earlier than April 14, 2003)].

Signature _____ **Date** _____

Part II - Determination of Request for Accounting of Non-Routine Disclosures of Personal Health Plan Information

Form II Prepared By	Date Form II Issued

After reviewing your request for an accounting of non-routine disclosures of personal health plan information, the Plan has made the following determination [check one of the following]:

☐ Request Approved without a fee (see section A below)

☐ Request Approved with a fee (see section B below)

☐ Request Denied (see section C below)

Section A: Request Approved without a Fee

Your request for an accounting of non-routine disclosures of personal health plan information is approved.

Your requested accounting of disclosures is attached to this form. There is no charge for processing request.

Section B: Request Approved with a Fee

Your request for an accounting of non-routine disclosures of personal health plan information is approved.

You requested and received an accounting of non-routine disclosures of personal health plan information, free of charge on _____ [Insert date that last free of charge accounting was disclosed]. The charge for processing this request is $_____ [Insert fee], as a fee for the preparation of your request for an accounting. You have the right to withdraw or modify your request for an accounting. Unless you contact Human Resources – Benefits Department at the following address 3715 Oakes Avenue, Everett, WA 98201 within 10 days from _____ [Insert date] to withdraw or modify your request, Human Resources – Benefits Department will mail you your requested accounting and will send you a bill for $_____ which you agreed to pay by signing Part I of this form.

Section C: Request Denied

Your request for an accounting of non-routine disclosures of personal health plan information is denied because none of your PHI was disclosed for a non-routine purpose.

If you wish to make a complaint, please contact Human Resources – Benefits Department at (425) 388-4710.

Name of Plan Representative	Signature of Plan Representative	Date of Determination

f. Authorization for Use and/or Disclosure of Health Information

Directions for the Plan's Administrator for Using Model Authorization Form

Providing Form. If any person wishes to request an Authorization for the use or disclosure of PHI in the Everett School Employee Benefit Trust, Authorization Contact should provide the person with this Form.

Receiving a Completed Form. Upon receipt of this Form Authorization Contact should initial and date the top right corner and must verify that the Form has been properly completed.

If the person submitting the Form is not the subject of the PHI, Authorization Contact should verify the identity and authority of the person and follow the procedures detailed in Section 3.03.

This model Authorization Form is intended to allow a person to have health information sent from Everett School Employee Benefit Trust's health plan (including its Business Associates, Insurers and HMOs) to a third party for non-health plan purposes, including Everett School Employee Benefit Trust. Everett School Employee Benefit Trust may want to modify the specific options described in Sections A – D of this Form to reflect the most common types of requests that occur for its plans.

The "Your Rights" section includes optional language. The first option assumes Payment, enrollment, and eligibility decisions are not conditioned on the signing of an Authorization. The second option says the Plan may require Authorizations prior to a person's enrollment to make enrollment/eligibility determinations or underwriting or risk rating determinations. The appropriate option should be selected, to reflect Everett School Employee Benefit Trust's practices.

Everett School Employee Benefit Trust could also amend this Form to be used by Everett School Employee Benefit Trust or an individual in requesting PHI from another covered entity in cases when an Authorization is required (either by the HIPAA privacy rule or that Covered Entity). However, the other Covered Entity is likely to require the use of its own Authorization Form.

This model Authorization Form complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). State laws may impose addition requirements. Everett School Employee Benefit Trust should review this form and state law issues with counsel.

Instructions for the Individual Completing this Authorization Form

- The Everett School Employee Benefit Trust (the "Plan") cannot use or disclose your health information (or the health information of your children or other people on whose behalf you can act) for certain purposes without your Authorization. This form is intended to meet the Authorization requirement.
- You must respond to each section, and sign and date this form, in order for the Authorization to be valid.
- If you wish to authorize the use and/or disclosure of any notes the Plan may have that were taken by a mental health professional at a counseling session, along with other health information, you must complete one (1) form for the counseling session notes and one (1) separate form for other health information.
- The sample responses given for each section below are not exhaustive and are meant for illustrations only. Under HIPAA, there are no limitations on the information that can be authorized for disclosure.

Section A: Health Information to be Used or Released. Describe in a specific and meaningful way the information to be used or released. Example descriptions include medical records relating to my appendectomy, my laboratory results and medical records from [date] to [date], or the results of the MRI performed on me in July 1998.

Section B: Person(s) Authorized to Use and/or Receive Information. Provide a name or specific identification of the person, class of persons, or organization(s) authorized to use or receive the health information described in Section A.

Section C: Purpose(s) for which Information will be Used or Released. Describe each purpose for which the information will be used or released. If you initiate the Authorization and do not wish to provide a statement of purpose, you may select "at my request."

Section D: Expiration. Specify when this Authorization will expire. For example, you may state a specific date, a specific period of time following the date you signed this Authorization Form, or the resolution of the dispute for which you've requested assistance.

Signature Line. If you are authorizing the release of somebody else's health information, then you must describe your authority to act for the Individual.

Authorization to Use and/or Disclose Personal Health Plan Information

Form Received By _____ Date _____

1. Employee Name:	**1a. Employee Health Plan ID Number:**
1b. Employee Date of Birth:	
2. Name of Person Whose Health Information is the Subject of this Authorization:	**2a. Relationship to Employee:** Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name:	**3a. Authority** **If you are not the person in Box 2, please describe your authority to act on his or her behalf:** _____ _____
4. Mailing Address for Records:	**4a. City, State, Zip Code:**

I hereby authorize Everett School Employee Benefit Trust ("Plan") to use and/or disclose the health information described in Sections A — E below.

[Alternative for Everett School Employee Benefit Trust: modify this section to specify the organization that will release the information on behalf of the Plan, such as Insurer, HMO, Business Associate, or Everett School Employee Benefit Trust]

Section A: Health Information to be Used and/or Disclosed.

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one (1) of the following boxes:

☐ All of my past, present or future health claims and/or medical records.

☐ All of my health information relating to Claim Number _____.

☐ Other (please specify). _____ _____

Section B: Person(s) Authorized to Use and/or Receive Information.

Specify the persons or class of persons authorized to use and/or receive the health information described in Section A: _____.

Section C: Purposes for Which Information will be Used or Disclosed.

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

☐ To facilitate the resolution of a claim dispute.

☐ As part of my application for leave of under the Family and Medical Leave Act (FMLA) or state family leave laws.

☐ For a disability coverage determination.

☐ At my request.

☐ Other (please specify)._____

Section D: Expiration of Authorization

Specify when this Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

☐ On the following date: _____.

☐ Upon the passage of the following amount of time: _____.

☐ Upon my disenrollment from Everett School Employee Benefit Trust's health plan.

☐ Upon my return from FMLA leave.

☐ Other (please specify) _____

Your rights:

- You can revoke this Authorization at any time by submitting a written revocation to Human Resources – Benefits Department at the following address: 3715 Oakes Avenue, Everett, WA 98201.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information by no longer be protected by HIPAA.
- **[Option 1: The Plan may not condition Treatment, Payment, enrollment or eligibility for benefits on whether I sign the Authorization.]**
- **[Option 2: This clause applies to individuals not yet enrolled in the Plan. If this Authorization was requested so the Plan can make an eligibility or enrollment determination or an underwriting or risk rating determination, then the person in Box 2 may be ineligible for enrollment or benefits if you fail to sign this form.]**
- You will be provided with a copy of this Authorization Form, after signing, if the Plan sought the Authorization.

_____

Signature of Participant & Date

10.09 List of Legally Required Uses, Public Health Activities, Other Situations Not Requiring Authorization

As described in Section 4, the Plan, its Insurers and Business Associates will, without obtaining a Participant's Authorization, use and disclose PHI if required by law, for certain public health purposes, and in other similar situations, described in the following chart:

Purpose for disclosure	Permissible disclosures of PHI
Workers' compensation	• Includes disclosures of PHI to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws.
Necessary to prevent or lessen serious threat to health or safety	• Includes disclosures of PHI to a person or persons if made under good faith belief that releasing PHI is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat). • Includes disclosures of PHI to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public health activities	• Includes disclosures of PHI authorized by law to persons who may be at risk of contracting or spreading a disease or condition. • Includes disclosures of PHI to public health authorities to prevent or control disease and to report child abuse or neglect. • Includes disclosures of PHI to the FDA to collect or report adverse events or product defects.
Victims of abuse, neglect, or domestic violence	• Includes disclosures of PHI to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if the subject of the PHI agrees or the Plan believes disclosure is necessary to prevent serious harm to the individual or potential victims; the

Purpose for disclosure	Permissible disclosures of PHI
	Plan will notify the individual that is the subject of the disclosure if it won't put the individual at further risk.
Judicial and administrative proceedings	• Includes disclosures of PHI in response to a court or administrative order; and disclosures in response to a subpoena, discovery request or other lawful process (the Plan is required to notify the individual that is the subject of the request for PHI of the request, or to receive satisfactory assurance from the party seeking the PHI that efforts were made to notify the individual that is the subject of the request for PHI or to obtain a qualified protective order concerning the PHI).
Law enforcement purposes	• Includes disclosures of PHI to law enforcement officials as required by law or pursuant to legal process, or to identify a suspect, fugitive, witness or missing person. • Includes disclosures of PHI about a crime victim if the individual that is the subject of the PHI agrees or if disclosure is necessary for immediate law enforcement activity. • Includes disclosures of PHI regarding a death that may have resulted from criminal conduct and disclosures to provide evidence of criminal conduct on the Plan's premises.
Decedents	• Includes disclosures of PHI to a coroner or medical examiner to identify the deceased or to determine the cause of death, and to funeral directors to carry out their duties.
Organ, eye, or tissue donation	• Includes disclosures of PHI to organ procurement organizations or other entities to facilitate cadaveric organ, eye, or tissue donation and transplantation.
Research purposes	• Includes disclosures of PHI subject to approval by institutional or privacy boards, and subject to certain assurances and representations by researchers regarding necessity of using PHI and treatment of PHI during a research project.
Health oversight activities	• Includes disclosures of PHI to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, compliance with regulatory programs, or civil rights laws.
Specialized government functions	• Includes disclosures of PHI of individuals who are Armed Forces personnel or foreign military personnel under appropriate military command authority.

Purpose for disclosure	Permissible disclosures of PHI
	• Includes disclosures to authorized federal officials for national security or intelligence activities. • Includes disclosures to correctional facilities or custodial law enforcement officials about inmates.
Department of Health and Human Services (HHS) Investigations	• Includes disclosures of PHI to HHS to investigate or determine the Plan's compliance with the HIPAA Privacy Rule.