MEDICAL OFFICE COMPLIANCE TOOLKIT

Table of Contents

This Compliance Toolkit includes over 75 online forms and documents that can be downloaded and customized to meet the needs of your practice. To access your online forms:

1. Login to your AAPC Member Account on the AAPC Web site (www.aapc.com)
2. In the left column, "View All" next to "Purchases"
3. Under the "Courses" tab, find the "Medical Office Compliance Toolkit"
4. Click that link to access your electronic forms and policy documents

Online Forms & Policies Index

Contents

HIPAA
Privacy Forms

BUSINESS ASSOCIATE LETTER

Dear _____,
("Business Associate")

As you are aware, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) encompasses significant instructions and requirements regarding the control and care of protected health information (PHI). The prevailing sections of the act are commonly known as the HIPAA "Privacy Rule." The rule mandates that numerous precautions be taken and safeguards put in place to protect our patients' protected health information from unwanted disclosure and possible unauthorized use.

As a result, we are sending you our "Business Associate Privacy Agreement." This agreement protects our patients, our practice, and you as a business associate with whom we might have occasion and necessity to share pertinent protected health information in order to effect proper treatment.

Our practice requires that all those with whom we do business comply with the law and always use their best efforts to serve our patients. Together, we can assure our patients that their treatment is superior and their confidence is well placed.

To this end, please sign and return the enclosed agreement.

Sincerely,

Employee Non-Disclosure / Confidentiality Agreement

I have read and understand [**clinic name**] policies regarding the privacy of individually identifiable health information (or protected health information ("PHI")), pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In addition, I acknowledge that I have received training concerning the use, disclosure, storage and destruction of PHI as required by HIPAA, and that I have read and understand the material set forth in the HIPAA Training Handbook(s) provided by [clinic name]. I further understand that, through my affiliation with [clinic name], I will be exposed to privileged, intimate and personal information in addition PHI (such information and PHI shall collectively be referred to as "PHI" herein).

I understand that HIPAA requires many of [**clinic name**] clients to have detailed policies and procedures in place that dictate how employees can use patient information, when they can disclose it, and how they should dispose of it.

In consideration of my employment with and/or compensation from [clinic name], I hereby agree that I will not at any time—either during or after my employment or affiliation with (a) [**clinic name**] or (b) its clients—use, access or disclose PHI in any manner to any person or entity, internally or externally, except as is required and permitted in the course of my duties and responsibilities with [clinic name] or its clients, and as permitted under their privacy policies and procedures as adopted and amended from time to time or as permitted under HIPAA. I understand that this prohibition includes, but is not limited to, disclosing any information about the identity of the patients with whom I work or any information about them, including their medical and other personal information, to family, friends, other patients, other clients, or co-workers, unless such person is lawfully authorized to receive such information. I agree to document uses and disclosure of PHI as required by the clients and/or HIPAA and to return or destroy all PHI associated with the clients upon the termination of my services. I agree that I immediately will report to [clinic name] and to the client with which I am placed any impermissible PHI use or disclosure.

I understand that my person access code, user ID, access key, password and similar access information will be kept confidential at all times. I understand that I will not remove from [**clinic name**] any devices or media unless instructed or authorized to do so. I agree to return all means of access to PHI upon termination of my employment with [clinic name].

I understand and acknowledge my responsibility to apply the policies and procedures of [clinic name]. I understand that unauthorized use or disclosure of PHI will result in disciplinary action, up to and including the termination of employment or affiliation with [clinic name] and its clients and could result in the imposition of civil and criminal penalties under applicable laws, as well as professional disciplinary action.

I understand that my obligations will survive the termination of my employment or end of my affiliation with [clinic name] and its clients, regardless of the reason for such termination. I understand that my obligations extend to any PHI that I may acquire during the course of my employment or affiliation with [**clinic name**] or its clients, whether in oral, written or electronic form and regardless of the manner in which access was obtained. I understand that I should contact an administrative officer of [**clinic name**] if I have any questions, comments or concerns about the training I received or my obligations under this agreement.

Signature of employee: _____ Date:_____

Print Your Name:_____

Contents

HIPAA
Security Forms

Employee Termination Checklist

(Practice Name)

_____ _____

Employee Name Termination Date

- ☐ All building keys or badges have been returned to Security Officer.
- ☐ Email access has been eliminated. Account has been forwarded to Security Officer.
- ☐ Voicemail access has been eliminated. Account has been forwarded to appropriate staff.
- ☐ Intranet / System passwords have been terminated
- ☐ Employee IT Access List has been updated.
- ☐ Employee directory has been updated (website, phone lists etc.)
- ☐ Personal Computer / Laptop has been returned
- ☐ PDA's, pager, cell phone has been returned
- ☐ Unused vacation / sick time credited for last pay check
- ☐ Termination letter outlining benefits status and end dates has been provided
- ☐ Confidentiality agreements that were signed have been reviewed with employee
- ☐ Final timesheet and expenses submitted
- ☐ Exit interview conducted

_____ Date: _____

Administrator / HR Signature

Contents

OSHA Forms

Request for Release of Exposure / Medical Record Information

(Name of Practice)

Patient Name: _____

Date of Birth: _____

Patient Address: _____
Street City, State Zip

Requested patient information
Please describe the information that you would like us to provide a copy of:

_____

_____

_____

We will review your request to determine if the information can be made available to you. In some cases, we may be legally prohibited from disclosing certain information. For further details please refer to our Notice of Privacy Practice.

We will complete our review of your request within the next 15 days and contact you either by phone or writing to arrange for you to pick up a copy of your records. First time requests for information is provided free of charge. If you need additional copies, an administrative fee of $_____ will be charged for copying the requested material.

If we are unable to accommodate or deny your request, we will notify you in writing.

_____ _____
Patient Signature or Personal Representative Date

Office Use Only

Request was received by: _____ Date:_____
(Name and title of staff receiving / processing this request)

- ❑ **We hereby accept this request.**
- ❑ **We hereby deny this request.**

_____
Practice Representative (Type/Print)

_____
Practice Representative Signature

_____
Date

Contents