Notice of Privacy Practices

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

Please Review It Carefully

Effective Date: September 22, 2013

Department of Elder Affairs’ Duties

This notice applies to the information and records we have about your health, health status, and the health care and service you receive from the Department in your personal file. It describes the information privacy practices followed by our employees, volunteers, staff and other office personnel. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We are required by law to notify you of our legal duties and privacy practices with respect to your health information. We are also required to maintain the privacy of your protected health information in our custody, and to follow the terms of this notice. If there is a breach involving your protected health information, we will notify you no later than 60 days following the discovery of the breach. The Department is required to abide by the terms of the notice of privacy practices that is currently in effect.

Uses and Disclosures of Your Protected Health Information

We may use or disclose your protected health information for the following purposes:

*Treatment - to provide you with medical treatment or services and to manage and coordinate your medical care. For example, your protected health information may be disclosed to a business associate of the Department to determine your medical eligibility for Medicaid long-term-care services.

*Payment - to bill and collect payment for your health-care services. We may disclose or use your protected health information to obtain or justify payment for your health-care services from various payment sources including federal and state funding programs such as Medicaid.

*Health care operations - to evaluate the performance of our staff in caring for you and to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. We may also use your protected health information to: contact you as a reminder that you have a scheduled appointment for treatment or medical care, inform you of potential treatment alternatives or options, or inform you of health-related benefits that may be of interest to you.

We may not use or disclose your information in the following circumstances without your authorization:

*Psychotherapy Notes - Any use or disclosure of psychotherapy notes, unless the notes are being used for treatment, payment, or health care operations, including mental health training programs, oversight compliance, research purposes, or as part of a legal defense.

*Marketing - Any use or disclosure for marketing purposes, except for face-to-face communication or promotional gifts to the individual.

*Sale of Information - Any sale of protected health information to a third party. We may not exchange your protected health information to a third party for money unless you consent.

There are special situations which allow us to use or disclose your protected health information without your permission. These situations include:

* To Avert Serious Threat to Health or Safety - to prevent a serious threat to the health and safety of yourself, the public or another person. We may disclose information to a family member or a close friend if necessary to assist you in a life-threatening emergency.

* Required by Law - when required by federal, state or local law, we must disclose or use your information to the extent required.

* Research - for research projects that benefit elders in Florida. The Department may disclose your information for research projects that have been approved by an institutional review board or privacy board that has analyzed the research proposal to review the effect of the research on your privacy rights and related interests.

* Organ and Tissue Donation - we may release information to organizations that handle procurement or transplantation, such as an organ donation bank, as necessary to facilitate
organ or tissue donation and transplantation.

* **Current or Previous Military, Veterans, National Security and Intelligence Members** - when required by military command or other government authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

* **Workers’ Compensation** - as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or similar programs. Such programs provide benefits for work-related injuries or illness.

* **Public Health Risks** - to public health or other authorities charged with preventing or controlling disease, injury or disability. We may also disclose your information to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with FDA-regulated products.

* **Health Oversight Activities** - for audits, investigations, inspections, licensing purposes, or other activities necessary for appropriate oversight, as authorized by law. These disclosures may be necessary for certain state and federal agencies to monitor the health-care system, government programs, and compliance with civil rights laws.

* **Lawsuits and Disputes** - in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose protected health information about you in response to a subpoena. We may also use or disclose your information to defend ourselves in the event of a lawsuit or administrative proceeding.

* **Law Enforcement** - for law enforcement purposes if required to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

* **Coroners, Medical Examiners and Funeral Directors** - to identify a deceased person or determine the cause of death. We may disclose your information to report vital events such as death, as permitted or required by law.

* **Volunteers** - to volunteers performing work for the Department, including, but not limited to, volunteers in programs such as SHINE, Sunshine for Seniors and State Long-Term Care Ombudsman.

* **Information Not Personally Identifiable** - we may disclose health information that does not personally identify you or reasonably reveal who you are.

* **Fundraising Activities** - to contact you for fundraising activities. You may elect not to receive fundraising communications by contacting the Privacy Officer in the Office of General Counsel.

**Other Uses and Disclosures**

We will not use or disclose your protected health information for any purpose that is not addressed in this notice without your specific, written authorization. If you give us authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the purposes covered by your written authorization. However, we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you. This is different than the authorization and consent mentioned above.

In order to disclose HIV or substance abuse records for purposes of treatment, payment, or health care operations, we will need both your signed consent and a special written authorization that complies with the law governing those records.

**Individual Rights**

You have the right to inspect and copy your protected health information. In order to do so, you must submit a written request to inspect and/or copy your protected health information. Your request may be denied in certain limited circumstances. However, if your request is denied, you may ask that the denial be reviewed. We will comply with the outcome of the review. As provided by 45 CFR §164.524, reasonable copy fees shall apply in accordance with State law.

You have the right to request a correction or change to your protected health information if you believe it is incorrect or incomplete, as provided by 45 CFR §164.526. Your request must be in writing and include a reason to support the request. We may deny your request if you ask us to amend information that:

a) we did not create, unless the person or entity that created the information is no longer available to make the amendment;

b) is not part of the health information that we keep; and/or

c) you would not be permitted to inspect and copy.

You have the right to request an accounting of disclosures, as provided by 45 CFR §164.528. This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. You may request an accounting of disclosures for a period up to six years prior to the date of your request. You must submit your request in writing. You are entitled to obtain one free copy of the accounting per 12-month period. For each additional request, we may charge you for the costs of providing the list, whether it is provided electronically or by paper copy. However, you may choose to withdraw or modify your request before any costs are incurred.
You have the right to request to receive communications of protected health information by alternative means or at alternative locations, as provided by 45 CFR 164.522(b). You may request that we communicate with you about medical matters in a certain way or at a certain location.

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations as provided by 45 CFR §164.522(a). If we agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to a paper copy of this notice. If you have agreed to receive it electronically, you are still entitled to a paper copy upon request to the Privacy Officer in the Office of the General Counsel.

Changes to This Notice
We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If this notice is revised or changed, we will post a summary of the current notice in the Department with its effective date. An up-to-date copy of this notice is available electronically on our website at www.elderaffairs.state.fl.us. You are entitled to a copy of the notice currently in effect.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint with our office or the Secretary of the U.S. Department of Health and Human Services, contact:

Privacy Officer, Office of the General Counsel
Department of Elder Affairs
4040 Esplanade Way
Tallahassee, FL 32399-7000
Voice Phone: (850) 414-2000
FAX: (850) 414-2004
TDD: (850) 414-2001

Region IV, Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 3870
61 Forsyth Street S.W.
Atlanta, Georgia 30303-8909
Voice Phone: (800) 368-1019
FAX: (404) 562-7881
TDD: (800) 537-7697

For Further Information
Requests for further information about topics covered in this notice may be directed towards the person who gave you the notice or to the Department of Elder Affairs, Privacy Officer, Office of the General Counsel at 4040 Esplanade Way, Tallahassee, FL, 32399-7000 or by phone at (850) 414-2000.
I hereby acknowledge that I have received and read this Notice of Privacy Practices.

________________________
Signature

________________________
Printed Name

________________________
Date (DD/MM/YYYY)
Employee Statement of Understanding of Privacy Policies
Department of Elder Affairs
4040 Esplanade Way
Tallahassee, FL 32399-7000
(850) 414-2000

I, ________________________________, have been trained and informed about the business and privacy practices in affect at DOEA as a result of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that I am responsible for ensuring the security, integrity and confidentiality of patient health information created, obtained and/or maintained by DOEA.

I have reviewed, understand, and agree to abide by the following Privacy Policies:

I. CONSUMER'S PRIVACY RIGHTS POLICY
II. NOTICE OF PRIVACY PRACTICES
III. BUSINESS ASSOCIATES
IV. RESPONSIBILITIES OF COVERED ENTITIES.
V. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
VI. DISCLOSURE TRACKING POLICY
VII. MINIMUM NECESSARY REQUIREMENTS
VIII. INDIVIDUAL RIGHTS TO PROTECTED HEALTH INFORMATION
IX. ADMINISTRATIVE REQUIREMENTS STANDARDS
X. DOEA GENERAL INFORMATION SYSTEMS ACCESS POLICY
XI. CHANGES TO POLICIES & PROCEDURE
XII. COMPLAINTS

I understand that non-compliance will be cause for disciplinary action up to and including dismissal from DOEA, and possible legal actions for violations of applicable regulations and laws.

I agree to promptly report all violations or suspected violations of any of the above policies to DOEA’s Privacy Officer through the designated reporting channels.

____________________________________________________________________
Print Employee Name

___________________________________________________ ________________
Employee Signature       Date

___________________________________________________ ________________
DOEA Signature          Date
I authorize DOEA to use and disclose my medical records for the purposes of Treatment, Payment and Health Care Operations.*

*Treatment includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This authorization includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

*Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

*Health Care Operations includes the necessary administrative and business functions of our office.

I further authorize DOEA to use and disclose the following specific health and medical information for the below listed purpose(s):

Specific medical information consisting of:

For the specific purpose of:

I understand and authorize my designated caregiver or personal representative to receive information described above.

I understand that I have the right to revoke this Authorization provided that I do so in writing, except to the extent that DOEA has already used or disclosed the information in reliance on this Authorization.

____________________________________
Signature of Client

____________________________________
Signature of Person Authorized by Law or Client

____________________________________
Date
If DOEA is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review DOEA's “Notice Of Privacy Practices” for additional information about the uses and disclosures of information described in this Authorization prior to signing this Authorization. Please verify that you have received a copy of our Notice by placing your initials here: ______.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.
REQUEST FOR RESTRICTION ON USE & DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION

FLORIDA DEPARTMENT OF ELDER AFFAIRS
4040 ESPLANADE WAY
TALLAHASSEE, FLORIDA 32399-7000

Client Name: ______________________________________________________________
Phone Number (Day):  _____________________________
Phone Number (Evening): __________________________
Street or PO Box: _________________________________
City: ____________________________________________
State: ___________________________________________
Zip: ____________________

1) Medical Information to be Restricted:

2) Nature of Restriction:

3) Medical Information to be Communicated Confidentially:

4) Alternative Location/Address/Telephone Number/E-mail:

TO OUR CLIENTS: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address, or telephone number and/or the alternative means of contact and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Client: ____________________________________________________________

Date:______________________
REQUEST FOR RESTRICTION ON USE & DISCLOSURE OF
MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION

Client Name: ______________________________________________________________

Case Manager Name: _______________________________________________________________________

Request for Restriction Accepted ______________

Request for Restriction Denied ______________

Request to Communicate Confidentiality Accepted _______________

Request to Communicate Confidentiality Denied ______________

This Request for Restriction and Confidential Communication Form is to be made a part of the medical record of: (Client Name) _______________________________________________
 REQUEST SECTION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request the opportunity to inspect and copy health information that pertains to you. The Department of Elder Affairs will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted you may request that the decision be reviewed by someone other than the person who originally denied the request.

I, (Client Name) __________________________ hereby request to inspect the following health information pertaining to me maintained at the Department of Elder Affairs:

_______________________________   _______________________________
Signature of Patient                                          Date
Access to Records Request for Inspection of Protected Health Information

REVIEW SECTION INTERNAL USE ONLY

This section is to be completed by the reviewer:

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<tr>
<th>Date received:</th>
<th>Reviewed by:</th>
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<tr>
<td>Chief Privacy Officer:</td>
<td>Review Date:</td>
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The inspection request is hereby:

Granted ____

Denied ____

If the request is denied, indicate the reason for the denial:

Reviewer’s Comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

_______________________________   _______________________________
Signature                                                          Date
REVIEW SECTION

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Reviewer's Decision:

Grant the Inspection Request ___
Deny the Inspection Request ___

Reviewer's Comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature ___________________________ Date ___________________________
Client Name: ______________________________________________________________

Phone Number (day): ________________________________________________________

Phone Number (night): _______________________________________________________

Street or PO Box: ___________________________________________________________

City: ______________________________________________________________________

State: _____________________________________________________________________

Zip: ______________________

1) Date of Medical Record Entry to be Corrected: ________________________________

2) Medical Record Language to be Amended/Corrected: _________________________

3) Amendment/Correction:

4) Reason for the Amendment/Correction:

5) Identify persons who have received the Information (prior to Amendment/Correction):

   Name Organization/Address       Phone Number

6) Do you authorize us to provide the information in Items no. 3 and no. 4 to the persons and organizations listed in Item no. 5?

   Yes ______

   No, do not provide the information to: ______________________________________

TO OUR CLIENTS: You have the right to submit a Medical Record Amendment/Correction Form to be made a part of your medical record. This right does not permit you to alter or change the original record created by your health care provider or his/her staff. We may deny your request to amend or correct your records.

Amendment/Correction Accepted: __________________

Amendment/Correction Denied: __________________
Reason for Denial: __________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

This Amendment/Correction Sheet Is to Be Made a Part of the Medical Record of:

Client Name: ________________________________________________________________
Date: _____________________________
Signature of Client: _________________________________________________________

If we have denied your requested amendment/correction, you have the right to submit a written
statement disagreeing with the denial and your reason for disagreement. We may reasonably
limit the length of your written statement, and we may prepare a rebuttal to your written statement
of disagreement (and provide you with a copy).

If we have denied your requested amendment/correction and you do not submit a written
statement of disagreement as discussed above, you may request that we include a copy of this
document with any future disclosures of the information identified in Items # 1 and # 2 above.

Please make your request in writing, and sign and date the request.

If you believe we have failed to meet our obligations as explained in our "Notice Of Privacy
Practices" or our legal obligations under state or federal law, you may contact the Privacy Officer,
General Counsel, of our office regarding your complaint. You may also file a complaint with
Secretary of the U.S. Department of Health and Human Services within 180 days of the date you
know or should know of the act that is the subject of your complaint. Your complaint to the
Secretary must be filed in writing, either electronically or on paper.

Privacy Officer, Office of the General Counsel
Department of Elder Affairs
4040 Esplanade Way
Tallahassee, FL 32399-7000
(850) 414-2000

Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 3B70
61 Forsyth Street S.W.
Atlanta, Georgia 30303-8909
Voice Phone: (404) 562-7886
FAX: (404) 562-7881
TDD: (404) 331-2867
FLORIDA DEPARTMENT OF ELDER AFFAIRS  
4040 ESPLANADE WAY  
TALLAHASSEE, FLORIDA 32399-7000

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request an accounting of disclosures of health information that pertains to you.

REQUEST SECTION

I, __________________________(Patient name) hereby request an accounting of disclosures of my protected health information that have occurred over the last _______________________.  
(Time Period - Up to 6 years)

_______________________________   _______________________________  
Signature                                                          Date

REQUEST PROCESSING SECTION - INTERNAL USE ONLY

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The requested disclosure accounting was processed on _______________________________.  
(Date)

_______________________________   _______________________________  
Signature                                                          Date
FLORIDA DEPARTMENT OF ELDER AFFAIRS
4040 Esplanade Way
Tallahassee, Florida 32399

I, [Name of Individual], hereby revoke the authorization for DOEA to use and disclose my protected health information to carry out treatment, payment or health care operations that I signed on [Date of Original Authorization]. However, DOEA may use and disclose my protected health information after I revoke my authorization, if DOEA treated me and I stated on the authorization form that DOEA could use and disclose my protected health information for treatment, payment, or health care operations prior to treatment. DOEA may no longer use or disclose my protected health information without my authorization after DOEA has treated me, obtained payment, and is no longer required to use or disclose my protected health information.

____________________________________
Individual’s Signature and Date

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

I, [Name of Individual] hereby revoke the authorization to release information I provided to DOEA that allowed DOEA to use and disclose my protected health information as I outlined on DOEA’s authorization form, which I signed on [Date] for release of my protected health information to [Name of Person or Facility]). I understand that this revocation does not apply to any action DOEA has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorizations to release information that I have provided to DOEA.

____________________________________
Individual’s Signature and Date

SPECIAL PROVISIONS

In this section, the individual should outline any special provisions regarding the revocation of the authorization.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

___________________________________________________________

______________________________________
Individual’s Signature and Date
Complaint Form
Florida Department of Elder Affairs
Privacy Officer
4040 Esplanade Way
Tallahassee Florida 32399-7000

As required by the Health Information Portability and Accountability Act of 1996 you have a right to complain about our privacy policies, procedures or actions. Florida Department of Elder Affairs will not engage in any discriminatory or other retaliatory behavior against you because of this complaint. Please be as thorough and forthright as possible.

Please complete the sections below:

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<th>Name:</th>
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<td>Address:</td>
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<td>Phone:</td>
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<td>Email Address:</td>
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<td>What is the best way to reach you?</td>
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<td>What are the best hours to reach you?</td>
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Details of your complaint: (Please be as specific as possible with dates, times and the specific policy, procedure or action taken; include the names, if any, of any one in the office with whom you discussed this. Use the other side of this form if you need more room.)

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______________________________                                           _______________________________
Signature                                                                                                   Date

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Reviewer's Comments:
FLORIDA DEPARTMENT OF ELDER AFFAIRS
CLIENT DISCLOSURE LOG

CARES OFFICE: ________________________________

CLIENT NAME ___________________________ CARES OR MEDICAD ID # ______________

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<thead>
<tr>
<th>DATE (DD/MM/YY)</th>
<th>TYPE OF INFORMATION DISCLOSED</th>
<th>RECIPIENT OF INFORMATION</th>
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DOEA Form 189 (04/03)
Fax Cover Letter

[Name of Health Care Provider]
[Address]
[City, state, zip code]
[Telephone number]
[Facsimile number]

Date;
Time:
Number of Pages Including Cover:

Recipient Information
To: [Name of Authorized Receiver]
[Name of Authorized Receiver's Facility or Practice]

Telephone: ______________________ Fax: ______________________

Sender Information
From: [Name of Sender]

Telephone: ______________________ Fax: ______________________

[Name of Health Care Provider or personnel] sending fax:

Comments: _____________________________________________

Confidentiality Notice: Confidential Health Information Enclosed

Protected Health Information (PHI) is personal and sensitive information related to a person’s health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law.

If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is Strictly Prohibited. If you have received this message by error, please notify the sender immediately to arrange for return or destruction of these documents.