# UNIT # 2

# Privacy Practices, HIPAA, and Ethical-legal issues

OVERVIEW

Healthcare workers are called upon to exercise professional behavior and make critical decisions daily. To best be able to fulfill the duties of a Medical Office Administrator (MOA), you must understand standards of practice, laws and ethics related to the healthcare industry. In this unit you will study the Health Insurance Portability and Accountability Act (HIPAA), Occupational Safety and Health Administration (OSHA) practices, and the American Medical Association (AMA). You will also consider ethical issues, explore options, and formulate courses of action.

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WHAT WILL YOU LEARN IN THIS UNIT?

After studying this unit, you will be able to:

1. Define terms from the list of vocabulary.
2. Explain the meaning of the Hippocratic Oath.
3. Identify standards for maintaining the privacy and security of health information.
4. List six patient rights.
5. Recognize unethical practices.
6. Describe the role of the Medical Office Administrator (MOA) under HIPAA guidelines.

Note, the term Medical Office Administrator (MOA) is interchangeable with the term Health Unit Coordinator (HUC) in this unit.

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# 01 Privacy


Max was shocked and outraged to find cell phone photos of his recent neuter procedure posted on his veterinarian's FaceBook page.

**Privacy… why is this important?**

It stands to reason that a person is much more likely to be forthcoming and honest about the information they share if it is kept in confidence and not shared with others. The patient physician relationship privilege guarantees all communication between the physician and the patient is confidential unless waived by the patient. If a patient is afraid to share information, it can affect the treatment outcome. Can you think of a situation where someone might not seek help if they believed that their health information would be shared with others? Consider the following scenario…

A 15-year-old girl has been nauseous and vomiting in the morning soon after she wakes up for the past week. Her mother who is concerned takes her to the emergency room. During the intake she is asked if she is sexually active. She replies that she is not. Tests are run and the cause of the girls vomiting is unclear. Additional tests are then run. Meanwhile the urinalysis result comes back and indicates that the girl is pregnant. When asked why she said she was not sexually active, she stated that she did not want her mother to know. Confidentiality and privacy in health care is important for protecting patients, maintaining trust between doctors and patients, and for ensuring the best quality of care for patients.

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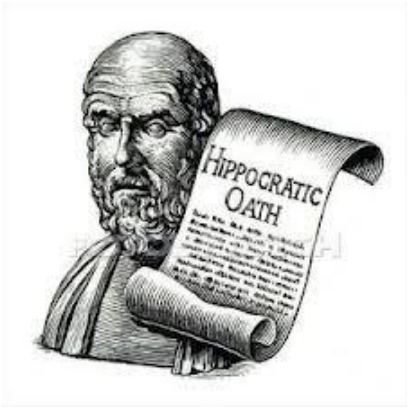
Commented [as2R1]: NHA 4A Ensure patient's privacy and security of protected health information.




**Confidentiality**

You have probably heard of the **Hippocratic Oath**, but do you know where it came from and what it means? The Hippocratic Oath dates to the fourth century and is a pledge attributed to Hippocrates, the father of medicine that addresses the ethical practice of medicine. It is an oath that physicians take to uphold ethical principles and to maintain privacy of information in the patient-physician relationship.

***Hippocratic Oath*** *"I swear by Apollo the physician, by Aesculapius, Hygeia, an d Panacea, and I take to witness all the gods, all the goddesses, to keep accord ing to my ability and my judgment the following oath: To consider dear to me as my parents him who taught me this art; to live in common with him and if necess ary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyo ne. To please no one will I prescribe a deadly drug, nor give advice which may c ause his death. Nor will I give a woman a pessary to procure abortion. But I will p reserve the purity of my life and my art. I will not cut for stone, even for patients i n whom the disease is manifest; I will leave this operation to be performed by pr actitioners (specialists in this art). In every house where I come, I will enter only f or the good of my patients, keeping myself far from all intentional illdoing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my pr ofession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oa th faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot."*

Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition.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The Hippocratic Oath has been modernized, but the foundation remains the same, that being that a physician should always preserve patient privacy.


"Not much going on here. I'm taking care of a 32 year old man who was in that big accident on the news this morning. Yeah, that guy. But nobody is supposed to know he's here."

**It is the law… Statement of Confidentiality**

All employees since 1996 when the Health Insurance Portability and Accountability Act (which will be discussed in more detail later in the unit) was enacted sign a **Statement of Confidentiality** as part of their new hire paperwork. The statement says that the employee agrees not to discuss patient information unless it directly relates to the job they are doing. It also states that an employee must not access records for patients that they are not entitled to view as part of their job. An example of that would be an employee wanting to look up a family member's medical record. It is not to say that the employee is not entitled to see the medical record, just that the appropriate procedures must first be followed, as in authorization must be given by the patient.

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All employees are responsible for keeping information secure and confidential. Confidentiality policies and procedures should be created and updated regularly.


Electronic records have a digital thumbprint or trail meaning that the provider who owns the record can see who has accessed the electronic medical record.

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There are several levels of accountability when patient confidentiality is breached. They are:

- Level 1 - Carelessness (unintentional)
- Level 2 - Curiosity (no personal gain)
- Level 3 - Personal Gain (malice)

The disciplinary sanctions for breaches in confidentiality range from a verbal warning/counseling to termination of employment and reporting to professional licensing boards.

The **Security Rule** is enforced by the Center for Medicaid and Medicare Sciences (CMS). The following actions and/or fines could be based upon a Security Rule violation: These same penalties can be imposed for Privacy Rule violations; however, the Privacy Rule is enforced by the Office of Civil Rights (OCR).

- Administrative Action (i.e., implement a corrective action plan)
- Civil Penalties ranging from $100 to $25,000
- Fines of up to $250,000 and imprisonment for up to ten (10) years

**Privacy Rule**

The Privacy Rule is federal protection for the privacy of health information. It requires physicians, hospitals, and other healthcare providers to obtain a patient's consent before using or sharing the patient's personal health information to carry out treatment, payment, or health care operations.

The standards of privacy of individually identifiable information otherwise known as the **Privacy Rule** was finalized in August 2002 by the United States Department of Health and Human Services. It created a national standard to protect a patient's personal and health information.

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Under the Privacy Rule patients are to be given a Notice **of Use and Disclosure** whose personal health information the doctor intends to share with others. Of note, the patient has a right to restrict those to whom their information is disclosed. A notice of use and disclosure must include the following information:

- Patient rights with respect to how their information will be shared.
- How to file a complaint against a provider
- How their information will be protected
- Who to contact for additional information?

Click the link below to view an example of a **Notice of Use and Disclosure** form.
https://eforms.com/images/2016/10/HIPAA-Authorization-for-Use-or-Disclosure-of-Health-Information.png

Whether paper or electronic records, it is imperative that MOC's maintain confidentiality. Follow employer/hospital policy and procedures and HIPPA rules and regulations to be in compliance.

**Medical Record**

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When talking about confidentiality and privacy, we are referring to a patient's Protected Health Information (PHI). HIPAA defines **Protected Health Information *(PHI)*** as any health-related information combined with a unique identifier that matches a particular individual. This information is documented in a **Medical Record,** a documented account of a patient's medical history.

**Medical Records** include the following sections:

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- Face sheet/demographics
- Admission forms
- Patient Right's
- Advance Directives
- History and Physical
- Admitting physician orders
- Physicians progress notes
- Nursing admits forms
- Nursing flow sheets/progress notes
- Graphic record form
- Medication Administration Record (MAR)
- Therapy notes (PT/OT/Speech/Dietary/Respiratory)
- Social Service/Discharge Planning
- Physician's Discharge Summary

Take a guess... match the following documents with the section of the medical record it can be found.

A. Consult Cardiologist ___ Advanced Directives
B. Patient Vital Signs ___ Face sheet//Demographics
C. Durable Medical Equipment (needs at discharge) ___ Orders
D. Living Will ___ Nursing Flow Sheets/Progress Notes
E. Next of Kin ___ Social Service/D/C Planning

(Answers at the end of the unit)

A medical record is a collection of all the information that the medical provider has about the patient. It is also a legal document that the medical provider must keep on each patient, and it is governed by law, accreditation agencies, as well by various rules and regulations set forth by the provider.

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**Security Rule**

Under HIPAA (which will be discussed in more detail later in this unit), The Security Rule went into effect in 2003 and spells out what are called **Individual Identifiers** *[45 CFR 164.514 (b)(2)(i)*][i] which apply to electronic records. They include:

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- Age
- Dates
- Phone numbers
- Fax numbers
- Email addresses
- Geographic (county/zip code)
- Social Security number
- Health plan number
- Certificate/License numbers
- Account numbers
- Vehicle plate numbers
- Medical device serial numbers
- Internet protocol (IP) addresses
- Photographs

Individual Identifiers are considered Protected **Health Information (PHI)** and is to be protected meaning that it should only be accessible to providers working directly with the patient. It is the Individual Identifiers that make the health information protected. In other words, if you were to read medical information such as the patient had an Open Reduction Internal Fixation (ORIF) it would not be considered confidential. If on the other hand you read that Patient (pt.) # 123998, an 82-year-old female Medicare (MCR) 122334 received a prosthesis with serial # 123445 it would be considered protected health information. Why? Because the pt. number, age, MCR number and medical device # all uniquely identify the patient. You could connect the health information with the patient.

So, when can PHI be shared and with whom? A covered entity under HIPAA's Privacy Rule may access, and share information for treatment, payment, and health care operations [45 CFR 164.506(c)][ii] Treatment means the provision, coordination or management of health care and related services between providers. Payment refers to determining eligibility under a plan, claims, utilization review and consumer reporting

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agencies. Healthcare operations involves administrative, financial, and legal activities, e.g., risk assessment and quality improvement, medical record review, and lawsuit. Other permitted disclosure includes to the patient, to certain government agencies, health oversight agencies, law enforcement, funeral homes, and research with patient authorization.

What about for minors? In most cases, the parent is considered the minor's personal representative who can make decisions regarding disclosure on the minor's behalf. The exceptions to that are if the parent agrees to the minor having a confidential relationship with the healthcare provider, or if the healthcare provider in their professional judgement believes the minor has been abused or neglected. Information that is of community concern such as sexually transmitted diseases is also considered disclosable and reportable to the Center for Disease Control.

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For more on privacy, go to http://www.hhs.gov.ocr/hipaa.

If a patient is hospitalized, the record is created and maintained by the hospital, governed by its policies and procedures and is a cumulation of everything that occurred during the patient's hospitalization. The record remains with the hospital after the patient is discharged. Though the hospital owns the medical record, HIPAA mandates that the patient owns the information in the medical record. Having said that, copies of the medical record should not be released without a signed request from the patient or a subpoena from the court. The same goes for if the medical record is created in a medical clinic or physician office.

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Bottom line is that the medical record is a legal document, and no one should have access to it that is not directly working with the patient. The MOA must protect medical records and maintain confidentiality. Violating confidentiality is a violation of ethical standards and the law.

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# 05 Legal and Ethical Issues

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Hudiemm/E+/GettyImages/RoyaltyFreeLicense

Ethical decision making in the healthcare setting occurs frequently as ethical dilemmas are found in every part of the health care system. Ethics involves what one feels is a moral obligation and ethical dilemmas are often subjective and open to more than one interpretation.

Consider the following case study…

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## Case Study

Jenna Peterson, a 20-year-old college student, made an appointment to be seen by Susan Grant, M.D., one of the partners at Mountainside Family Medicine Associates. Jenna had been seeing Dr. Grant for a few years. Dr. Grant was also the long-time family practitioner for Jenna's mom and older sister. On this visit, Jenna said she would like to get a prescription for birth control pills. They discussed other contraception options, as well as the risk and benefits of each and decided that "the pill" would be Jenna's best option. After reviewing Jenna's medical history and performing a brief physical examination, Dr. Grant gave Jenna a six-month prescription for Ortho-Novum 10/11, along with educational materials on oral contraceptives. She told her to schedule a six-month follow-up appointment over summer break. When Jenna checked out with the front office, she told the billing office that she did NOT want this visit submitted to her mother's insurance. Instead, she would pay for the visit herself because she did not want her mother to know the reason for the visit. The billing clerk said that she would send Jenna a bill because the practice's billing system was undergoing a software upgrade. Jenna asked that the bill be sent to her college address.

About two weeks later, Mrs. Peterson had a routine appointment with Dr. Grant. When she checked in, she stopped by the billing office and asked the insurance clerk to check a notice of claim statement she recently received from her insurance carrier about a visit by Jenna. Mrs. Peterson said, "I know Jenna hasn't been here because she's away at school." The clerk said she would check on the claim and should have information for Mrs. Peterson by the time she was done seeing Dr. Grant. Mrs. Peterson was then taken back to an exam room for her appointment. While seeing

Mrs. Peterson, Dr. Grant inquired about the Peterson family and mentioned that "Jenna has really blossomed into a beautiful, intelligent young woman." Mrs. Peterson thanked Dr. Grant and asked, "When did you see Jenna?" Dr. Grant unthinkingly said, "Oh, a couple weeks ago when she was in for her appointment." When Mrs. Peterson questioned why Jenna had been seen, Dr. Grant realized she had said too much. She hemmed and hawed a bit, and finally suggested that Mrs. Peterson talk to Jenna. Despite Mrs. Peterson's insistence that she had a right to know why Jenna was seen, Dr. Grant refused to provide additional details. Mrs. Peterson was clearly angry with that response and stormed out of the exam room. On her way out, she stopped at the billing office, and the insurance clerk confirmed that Jenna was in for an appointment on the day in question and that the claim was correct.

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Take a minute to consider the scenario above and then answer the following questions:

- Did any violations occur in the scenario? If so, what was violated and what regulation and/or law does it pertain to? Include level of accountability for each violation you find.
- What, if anything could have been done differently?

**Conclusion**

Healthcare workers interact with the law in numerous ways. There are standards of practice for medical professionals that if not followed can result in civil or criminal penalties for the individual and the employer. It is, therefore, important to understand how the law affects the healthcare profession and the Medical Office Administrator.

Failure to comply with HIPAA rules and regulations can result in a lawsuit for improper disclosure. Medical facilities must therefore assess risk and safeguard against violations. HIPAA recommends that all staff be educated and trained on rules and regulations regarding disclosure of patient information and that written policies are in place. HIPAA also recommends assigning a privacy officer to oversee compliance and taking precaution by using best practices such as strong passwords for electronically stored patient information and encryption when transmitting to another covered entity.

In closing, the Medical Office Administrator / Health Unit Coordinator serves an especially important function in the delivery of healthcare services engaging in a range of duties from creating and maintaining medical records to serving as receptionist and coordinating patient procedures. The most important function, however, is the ability to maintain confidentiality and privacy of a patients protected health information. By understanding and following the rules and regulations related to privacy and confidentiality, the MOA improves access to healthcare information, streamlines the provision of services, prevents breaches, improves efficiency, and creates patient confidence and trust. Securing patient information will also keep the MOA and the healthcare provider from violating laws and regulatory agencies policies.

So, how can you do this as a Medical Office Administrator? Be proactive. Follow best practices, adhere to employer policies and procedures, stay abreast of current trends

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and developments, sit on a compliance committee, subscribe to an industry journal, or seek certification. To learn more about becoming a certified MOA checks out the following links:

https://learn.org/articles/Health_Unit_Coordinator_Become_a_Health_Unit_Coordinator_in_5_Steps.html#:~

https://www.ncctinc.com/certifications/moa

https://www.nhanow.com/

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## Vocabulary

**AMA –** The American Medical Association, founded in 1847 and incorporated in 1897, is the largest association and lobby group of physicians whose mission is to promote the art and science of medicine and the betterment of public health.

**Authorization -** a patient's permission for uses and disclosures of the patient's protected health information for any purpose other than by a covered entity carrying out treatment, payment, or its own health care operations (65 Fed. Reg at 82509-10, 82512-13, 82519-20, (164.502) (a) (1) 9iv), 164.508).

**Consent -** – a patient's written permission for uses and disclosures of the patient's protected health information by a covered entity to carry out treatment, payment, or health care operations (164.502 (a) (1) (ii)-(iii), 164.506.

**Disclosure** – release, transfer, or divulge information outside the entity holding the information, or provide access to the information for an entity other than the entity holding the information (164.501)

**Encryption -** The process of encoding information so that it cannot be read or understood by anyone except those using a system that can decrypt it with a key.

**Health Care Provider's** persons, businesses, and those entities who provide health care and billing services.

**Health Plans - A**ny group that pays for the cost of services, public as in MCD/MCR and private such as HMO's/PPO's.

**Health Clearinghouses -** Entities public or private that process health information, e.g., the cloud

**HIPAA -** Legislation for the Health Insurance Portability and Accountability Act was passed in 1996 which covers multiple issues, the most well-known being that of confidentiality of personal health information (PHI).

**Hippocratic Oath –** A pledge that physicians take to uphold ethical principles and to maintain privacy of information in the patient-physician relationship.

**Medical Office Administrator (MOA) /Health Unit Coordinator (HUC)**
A member of a health care team who is responsible for non-clinical patient care.

**Medical Record –** A documented account of a patient's medical history.

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**The Occupational Safety and Health Administration (OSHA**) - Ensures safe working conditions for all employees.

**Patient Rights** -A set of standards that defines the rights a patient has over their personal health information.

**Protected Health Information *(*PHI*)*** – Any health-related information combined with a unique identifier that matches a particular individual.

**Safety Data Sheet (SDS) -** A globally harmonized system for classifying chemicals that replaced the MSDS.

**Resources**


http://www.apapractice.org/

https://www.ama-assn.org/

https://aspe.hhs.gov/report/nrpm-security-and-electronic-signature-standards/electronic-signature-standard

https://www.fda.gov/ForPatients/Approvals/Fast/ucm405399.htm

https://www.hhs.gov/hipaa

https://www.hhs.gov/hipaa/for-professionals/security/guidance/final-guidance-risk-analysis/index.html

https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html

http://www.healthit.gov/providers-professionals/security-risk-assessment

http://www.hhs.gov/ocr/office/index.html

http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/index.html

http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityruleguidance.html

https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf

https://www.osha.gov


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https://www.usa.gov/federal-agencies/occupational-safety-and-health-administration



**Answers**

**Medical Record Matching**

A. Consult Cardiologist
A. Patient Vital Signs
B. Durable Medical Equipment
D. Living Will
E. Next of Kin

D Advanced Directives
E Face sheet//Demographics
A Orders
B Nursing Flow Sheets/Progress Notes
C Social Service/D/C Planning

**Case Study (Findings)**

Allegations and Claims Investigation Jenna Peterson's right to privacy was obviously compromised by both Dr. Grant and her billing office. Both Jenna and Mrs. Peterson terminated their relationship with Dr. Grant and Mountainside Family Medicine Associates as a result of the incident. Jenna initially threatened to sue the practice for a breach in patient confidentiality, HIPAA noncompliance and emotional distress. Though she never followed through on the suit, she filed a formal HIPAA Privacy Violation Complaint against both the physician and the practice with the Office of Civil Rights (OCR). The investigation into the case found Dr. Grant at fault for revealing that Jenna had been seen as a patient. Her disclosure was not malicious—just not well-thought out. However, even if Dr. Grant had not mentioned Jenna's visit, her privacy would have been breached when the practice filed the claim with Mrs. Peterson's insurance, in spite of Jenna's arrangement to the contrary. Dr. Grant admitted she should not have mentioned Jenna to Mrs. Peterson, particularly after the physician had reassured Jenna that her request for "the pill" would go no further. The breakdown in the billing office was blamed on the fact that the system was "offline" the day of Jenna's visit. The clerk's note concerning Jenna's instructions about her bill never made it into the system, and the claim was automatically submitted to Mrs. Peterson's insurance company. However, Jenna received a bill from the office several weeks later, and she submitted her payment. This created other problems for the practice because Mrs. Peterson's insurance had also paid on the claim. The OCR's investigation into this complaint found several areas where the practice, as a covered entity, was not in compliance with HIPAA Privacy regulations. The practice had no specific policies and procedures in place for

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protecting patient confidentiality, other than a record release policy. Although the practice had a named privacy officer, the worker had never performed or been assigned any duties in that regard. Neither had the practice performed a risk assessment to determine where patient privacy safeguards were lacking or could be improved. The practice's new staff orientation program did not cover the issue of patient confidentiality in any detail, nor was there any specific staff training program in place with regard to HIPAA and patient privacy.

The OCR mandated HIPAA training of the entire practice staff—professional and ancillary. This was required to take place immediately and with ongoing, regularly scheduled refresher training sessions held. The OCR also suggested the practice perform a root-cause analysis to determine what steps the practice and Dr. Grant should have been taking to prevent the unauthorized disclosure of information. Based on the results of the risk assessment, the practice developed and implemented appropriate corrective and preventive measures.

What Can We Learn? A physician's duty to protect confidential patient information long predates laws and regulations like HIPAA or HITECH that mandate the protection of patient health information (PHI). In fact, it is addressed in the Hippocratic Oath: Whatsoever things I see or hear concerning the life of men, in my attendance of the sick or even apart therefrom, which ought not be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets. Oath of Hippocrates, 4th Century, B.C.E. Protecting patient confidentiality has long been recognized as inherently important to the practice of Medicine. It is necessary to foster the free exchange of information that guides the physician in the diagnosis and treatment of a patient. It also is critical to establishing trust and rapport, which are essential to a strong physician/patient relationship, patient satisfaction, and good clinical outcomes. And once that duty is breached, it can be next to impossible to rebuild the physician/patient relationship or regain the patient's trust. Patients must feel confident that personal information they share with physicians or staff will not become public knowledge or be released to third parties without their authorization and/or consent. Without that assurance, a patient may be reluctant or unwilling to provide personal or sensitive information that could be critical to his or her care. The diagnostic process can be difficult enough when a physician has access to all available information. If pieces of information are missing, the patient's health and treatment outcome may be jeopardized. The physician's duty of confidentiality extends to each staff member, and every employee has an inherent duty to protect patient information. No patient information may be released without the patient's express permission (except for emergencies). Unauthorized disclosure can result in malpractice allegations, along with HIPAA violations. Unfortunately, this case demonstrates how easily patient confidentiality can be violated. The disclosures of Jenna's care had not been done maliciously, criminally, or even consciously. There was no sophisticated technology involved. The root cause was simply a lack of understanding about the physician and staff's role in protecting patient confidentiality and a failure to have policies and procedures in place to prevent a breach. The issue of protecting patient confidentiality and PHI has renewed importance with the long-awaited publication of the final privacy rules on January 17, 2013. The HIPAA Final Omnibus Rule1 clarifies and

defines changes to the original HIPAA of 1996 regulations necessitated by the Patient Safety and Quality Improvement Act of 2005 and the Health Information Technology for Economic and Clinical Health Act (HITECH) Act of 2009. According to HHS, the final rule enhances a patient's privacy protections, provides individuals new rights to their health information, and strengthens the government's ability to enforce the law.

**Knowledge Check**

Answer the following True/False questions to get an idea of your level of understanding of the information presented in this unit.

_T___ A pandemic is a sudden outbreak of disease that becomes widespread affecting the world globally.

_F__ It is best to document in a medical record in pencil so that you can erase if mistakes are made.[Entries in a Medical Record should be in blue or black ink only and if a mistake is made a single line should be made through the incorrect entry, the word, 'error' written and the entry initialed].

_T__ HIPAA requires that a person within the healthcare practice be appointed privacy officer to ensure policies are created, implemented, and followed.

_T_ The Department of Justice prosecutes criminal violations of HIPAA's Privacy practices.

__T__ A patient has the right to restrict how their personal health information is shared.

_F__HIPAA created the Materials Safety Data Sheet (MSDS). [OSHA created the MSDS].

_T__Failure to comply with HIPAA rules and regulations can result in a lawsuit for improper disclosure.

__T_ Electronically kept medical records should be encrypted.

__F_ Consent is specific as to what information can be shared. [Authorization is specific while Consent is a general permission to use and disclose PHI with healthcare providers who have a direct relationship with the patient.]

__T_ The Privacy Rule is simply federal protection for the privacy of health information.

__T_ Any employee can contact OSHA to request an inspection or file a complaint about dangerous work conditions.

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__F__ Employees who provide direct patient care sign a Statement of Confidentiality upon hire. [All employees since 1996 working in the healthcare industry sign a Statement of Confidentiality upon hire.]

__F__Healthcare clearinghouses include HMO's and PPOs. [Healthcare Clearinghouses are the businesses that store and process healthcare information such as a shared database or clinical repository]

**More Practice**

1. Your supervisor has a potential new hire shadowing you for the day. The first form you would want to have that person sign is _____ (Statement of confidentiality).

2. The medical director of a nursing unit asks you to have his patient sign _____ so that he can share personal health information with a physician he wishes to consult with on patient care (Notice of Use and Disclosure).

3. You notice that maintenance has been using a strong-smelling solution to clean your nursing unit. Patients complain and it gives you a headache. You decide to check the _____ (Materials Safety Data Sheet).

4. You receive an email from a coworker with a photograph taken before a cosmetic procedure of a patient she thinks is cute. You know this a violation of _____ (The Security Rule/Individual Identifiers).

**Appendix**



[i] https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html
[ii] https://ecfr.io/Title-45/Section-164.506

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Standard Sets

FL MO1 8212201 Medical Office Technology 1 All standards must be taught and assessed.
FL HU1 8417281 Health Unit Coordinator 1 All standards must be taught and assessed.
GA No state standards
TX No state standards
VA 6730 Medical Administration All standards must be taught and assessed.
NCMOA  NCMOA National Certified Medical Office Assistant Certification Exam
All standards must be taught. Assess standards that echo other standards only.
NHA  NHA Medical Administrative Assistant Certification Exam

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