General Information

The University of Kentucky HealthCare complies with the Health Insurance Portability and Accountability Act (HIPAA) because we are a provider of services and are considered a covered entity. Education of HIPAA is a federal requirement and elicits trust from our patients. Please read the overview of HIPAA below and retain this document for reference as you continue through your volunteer experience.

HIPAA Basics

HIPAA and State Law mandates

- The privacy and security of Protected Health Information (PHI)
- Portability of health insurance
- Simplification of electronic billing

Purpose of HIPAA

- Protects the privacy of an individual’s health information
- Ensures physical and technical security of an individual’s information
- Governs the use and disclosure of an individual’s health information for treatment, health care billing, research, marketing and other functions

Patient Benefits of HIPAA

- Patients receive communication on how patient data will be utilized
- Patients have availability to their patient data
- Patients are informed when patient data is disclosed to outside parties

Protected Health Information (PHI)

- PHI is defined as facts about an individual’s past, present, or future physical or mental health condition
- HIPAA protects all information that can identify a patient in combination with their health information
  o This includes 18 identifiers such as name, dates of interest (birthday, admission date, death), address, SSN, telephone number, medical record, photographs, email/URL/IP address number
  ▪ For additional qualifiers, please contact Volunteer Services – when unsure, assume a qualifier; you must always protect all PHI

The HIPAA Privacy Rule

- Establishes minimum safeguards to protect confidentiality of an individual’s health information
- Protects an individual’s health information in all forms such as:
  o Electronic, paper, spoken, as well as the past, present, and future information
  o Living and dead
  o Groups in both public and private sector

The HIPAA Security Rule

- Maintains confidentiality, integrity, availability, and privacy of employee, patient, physician, research subjects, and University information
- Applies to all information that is created, communicated, stored, or processed
- If you have access to written or electronic confidential health information, you may be asked as a condition of your affiliation with UK, to sign a confidential agreement.
HIPAA & You

Tips and Best Practices

- Securely store all information (paper and electronic) and never share passwords
- Sign out of all applications and log off of your workstation when done
- Dispose confidential or protected health information properly by shredding or placing in secured bins
- Follow guidelines when transmitting information by email, fax, phone, or by other means
- Never discuss a patient’s medical information in public, even if you think you are alone

Always Remember

- You are entering an environment that services large volumes of individuals and you are likely to encounter confidential information during your experience
- You will have some interesting and exciting experiences; you may see well-known individuals or people you know, and you may want to share these events with your family and friends, or on social media. But, it is imperative to only speak about your experiences with individuals who have a business related, need to know, relationship with you (a rare occasion)
- Communicate with general references whenever possible
  - Example of specific reference: “Jane Doe was referred to a cardiologist.”
  - Example of general reference: “The patient was referred to a cardiologist.”
- UK Healthcare wants to educate and support our volunteers; so, ask for help when in doubt
- All information regarding an individual’s health care is confidential and should be protected

Penalties for Violation

- The University of Kentucky will not be responsible for individual penalties if the breach was intentional or happened outside the scope of your volunteer responsibilities
- Disciplinary action by UK HealthCare, up to including termination of your volunteering and/or expulsion from the academic program
- Federal and civil penalties exist for violations and individuals could be subject to the following charges:
  - For violating HIPAA: $100 per violation, up to $25,000 per person/year, for each requirement or prohibition violated
  - For knowing about violations: up to $50,000 and one year in prison
  - Intent to sell, transfer or use: up to $250,000 and up to 10 years in prison

Always Report Violations

- Report to your Supervisor or Volunteer Services who will investigate the situation
- Contact the office of Corporate Compliance at 859-323-8002 or richard.chapman@uky.edu
- Report anonymously to the ComplyLine at (877) 898-6072
  - Please be as detailed as possible because the Comply Line is completely anonymous and only knows the information reported
In order to receive credit for HIPAA training-level one, you must complete the following questions with 100% accuracy as well as fill in the employee information at the end of the questions.

**HIPAA Quiz**

1. HIPAA (Health Insurance Portability Accountability Act) protects an individual’s health information, is confidential and should be protected.
   - [ ] True
   - [ ] False

2. HIPAA protects an individual’s health information in which of the following forms?
   - [ ] Electronic
   - [ ] Paper
   - [ ] Spoken
   - [ ] All of the above

3. If you intentionally violate any of the provisions of the HIPAA law after receiving this training, you will NOT be covered by the University's liability insurance and therefore will be personally responsible for any fines, penalties, or imprisonment.
   - [ ] True
   - [ ] False

4. All information regarding any individual's health care is confidential and must not be shared with anyone who does not have a work-related need to know.
   - [ ] True
   - [ ] False

5. If you have access to written or electronic confidential health information, you may be asked as a condition of your affiliation with the University of Kentucky to sign a confidentiality agreement.
   - [ ] True
   - [ ] False

**HIPAA Acknowledgement**

☐ I certify that I have read the *HIPAA Education for Volunteer Services* document and will comply with HIPAA during my time with UK HealthCare Volunteer Services

______________________________  ____________________
Printed name of Volunteer          Date

______________________________  ____________________
Signature of Volunteer             Last four digits of SSN

UKHC Volunteer Services
UK Chandler Hospital | 1000 S. Limestone | Pavilion A – Room A 01.129 | Lexington, KY 40536
859-323-6023
If you are under the age of 18, your parent or legal guardian's signature is also required below.

☐ I certify that I am this individual's parent or legal guardian. Furthermore, I acknowledge the information outlined in the HIPAA Education for Volunteer Services document and understand I am liable for the minor's complain with HIPAA.

__________________________________________________________
Printed name of Parent/Legal Guardian

__________________________________________________________
Date

__________________________________________________________
Signature of Parent/Legal Guardian

__________________________________________________________
Printed name of Volunteer
Parent/Guardian Permission Form
2019 Summer Teen Volunteer Program
UK Chandler Medical Center

I ____________________________________________ as a parent and/or natural guardian of ________________________________ a minor, request and permit him/her to serve as a volunteer at the UK Chandler Medical Center. I am advised, and consent for his/her services, which will, unless specifically excluded, authorize ________________________________ to enter all areas of the Medical Center’s interest. I therefore give my consent ________________________________ for my son/daughter to volunteer at UK Chandler Medical Center, and agree to provide transportation and lunch on their behalf.

I acknowledge that my child must attend MANDATORY ORIENTATION on Wednesday, June 12, 2019 from 9am – 4pm.

I acknowledge that unless my child completes at least 5 of the 6 weeks of the summer program from June 17 – July 26, 2019, he/she will not receive documentation for ANY hours completed.

__________________________________________
DATE

__________________________________________
PARENT/GUARDIAN SIGNATURE