OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,

as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package,
Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)

November 12, 2014

Dear Representative:

On Sat. November 8th I had an 11AM appointment. My train was delayed by a half-hour due to serious altercation between 2 commuters. My delay was explained to the receptionist, (b)(6);(b)(7) (b)(6);(b) phoned her "manager" and informed I would be seen at 2PM as a result of my "lateness" and "over booked patients". Although only 1 other patient sat in the waiting area, (b)(6); urged me to leave the office to return again at 2PM. I opted to wait there (because another appointment would had been a month away) until I witnessed a Caucasian patient originally schedule for a 10AM appointment whom was seen immediately. Their conversation could be heard from where I sat, whereas that patient didn't offer or was asked for reason of her lateness. (b)(6);(b) chose to excuse that patient's one-hour-and-a-half lateness over my 30 minute train delay. I asked for my records, she said to "ask the doctor for it". She had no response on questions of blatant unequal treatment. (b)(6);(b) refused to offer her supervisor's information. Instead she asked if I "would like to cancel my 2PM appointment?". "Yes" I answered, suggesting their policies needed to be changed. I left without being seen and still experiencing physical discomfort from a concern that wasn't evaluated by a doctor.

On Mon. November 10th I phoned the Planned Parenthood hotline to register a complaint. I still experienced discomfort from a medical concern delayed by difficulty gaining access to care. (b)(6);(b)(7 of the Patient Records Department logged the complaint and tried to forward my call to (b)(6); (b)(6);(b) the clinic Director. After being on hold (b)(6);(b) took my info and said the Director would contact me. Once I was contacted by (b)(6);(b)(7)(C) I explained all instances of unjust treatment. She denied discrimination against insurances or patient demographic. She asked me to come in at 1PM with a detail report. In the office I was disappointed by (b)(6);(b)(7)(reluctance to meet with me. Unable to register a formal complaint, I requested all medical records from 2010 -2014. A male receptionist was helpful although (b)(6);(b)(tried to interfere with the paperwork process to release my records. (b)(6);(b stated, "she should ask the doctor not us." I did get my records before being seen. It is unfortunate this time their preferential broke confidences in remaining a patient.

The earliest incident of similar maltreatment was on Sat. January 4th when I walked-in (without an appointment) with an emergency concern at about 10AM. On a previous visit, I been informed by my then gynecologist (b)(6);(b)(7)(C), that Planned Parenthood accepts returning patients as walk-ins. However, on January 14th an largely overweight African American woman with a walking-limp rudely tried to deny service. She was loud when openly asking about my symptoms in a waiting area full of people. After describing my problem, I realized this humiliating action was in violation of the HIPAA Privacy Act. She claimed they didn't take walk-ins. I asked to speak with her manager. Oddly enough the female supervisor was seated by an open doorway labeled Healthcare Associate Supervisor. The supervisor reluctantly told me to return at 3PM, and suggested I leave the office until then. That manager was close enough to overhear how I was being spoken while having my privacy as far as symptoms violated. It seems this disrespectful work culture against certain patients was condoned. I sat in the waiting area instead. Moments later a Caucasian patient approaches the same

receptionist. That patient clearly stated she "didn't have an appointment but needed to be seen". The disrespectful receptionist's attitude was suddenly polite as she handed the (Caucasian) walk-in a clipboard and was soon taken in for treatment. On that day I was the last person seen before the office closed because the 2 receptionists neglected to enter my paper, until a security on duty (seated at the post across from them) informed me they hadn't. I explained the incident to my new doctor and she advised I make an appointment next time. I was the last patient seen by evening.

Today, November 12th, I did receive a call from (b)(6);(b)(7)(C) only after phoning the complaint hotline. I was uncomfortable sharing info due to her reluctance to meet with me on Monday. It shouldn't have taken a second complaint for her to follow up. After phoning the Washington DC office, Associate Vice President (b)(6);(b)(7)(C) returned my call. I had submitted and email detailing each visit. My experiences led me to question the sincerity of the entire staff.

In each instance I been made to feel demoralized when seeking care. Based on the unequal treatment witnessed, there seems to be pattern of discrimination involving Medicaid or race. This is a serious violation of a patient's civil rights and access to quality care. I am uncertain if anyone in position at Planned Parenthood cares at this point. However, it is important that Planned Parenthood's policies are reexamined.

Cordially,

(b)(6);(b)(7)(C)

Planned Parenthood of New York City

26 Bleecker Street

New York, NY 100122413

212-965-7000

800-230-PLAN

Directions: Map It!

Dear (b)(6); (b)(7)

You have an upcoming appointment at our New York health center. Please take a minute to review the details of your appointment.

Appointment Details
Date: 11/08/2014
Time: 11:00 AM

If you are unable to make your appointment, you may cancel or reschedule on our portal at https://health.eclinicalworks.com/ppnyc, or you may call us at (800) 230-PLAN or (212) 965-7000.

Please remember to bring your photo ID and insurance card to your appointment. We accept cash, checks and credit cards as forms of payment.

We look forward to seeing you.

Sincerely,

Planned Parenthood of New York City

Planned Parenthood of New York City

26 Bleecker Street

New York, NY 100122413

212-965-7000

800-230-PLAN

Directions: Map It

Dear (b)(6);

You have an upcoming appointment at our New York health center. Please take a minute to review the details of your appointment.

Appointment Details
Date: 11/08/2014
Time: 2:00 PM

When you receive this message please log onto our portal at https://health.eclinicalworks.com/ppnyc. We may have sent you a message with important instructions on how to prepare for your visit.

If you are unable to make your appointment, you may cancel or reschedule on the portal, or you may call us at (800) 230-PLAN or (212) 965-7000.

Please remember to bring your photo ID and insurance card to your appointment. We accept cash, checks and credit cards as forms of payment.

We look forward to seeing you.

Sincerely,

Planned Parenthood of New York City

New, expanded hours at the Planned Parenthood in Staten Island! Mondays and Wednesdays: 9am to 6:30pm and Thursdays: 9am to 7:30pm. As of July 1, the Planned Parenthood in Manhattan also has expanded hours: Mondays, Tuesdays, and Fridays: 8am to 6pm; Wednesdays and Thursdays: 8am to 8pm. It also remains open on Saturdays, 8am to 4:30pm.

On three separate visits this year, I've been made to feel unwanted in by Planned Parenthood of NY 26 Bleeker Street practice. It seems a negative change in attitudes with the predominantly Black front end staff occurs once my insurance info is looked up. There has been repeated incidences dehumanizing behaviors while having morning appointments bumped to late afternoons/evening. Staff will put more effort into pressuring me to leave the office than to process my paperwork. Opting to stay in the waiting area, I've witnessed Caucasian patients be accommodated immediately with similar circumstances as me. Directors, Supervisors, Doctors and Nurses do NOT respond to complaints on obvious unequal treatment of patients. I have been a patient of this location from 2010-2014. There has not been a problem until this year. Attached are detailed incidences experienced this year with the November 8th appointment change email.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019
TDD - (202) 619-3257
Fax - (202) 619-3818
http://www.hhs.gov/ocr

Office for Civil Rights
200 Independence Avenue, S.W.,
Room 509F
Washington, DC 20201

January 15, 2015

(b)(6);(b)(7)(C)

RE: OCR Transaction Number: 15-199202

Dear (b)(6);(b)(7)(C):

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) regarding Planned Parenthood of New York.

OCR enforces Federal civil rights laws that prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and, under certain circumstances, sex and religion. OCR also has jurisdiction over health plans, health care clearinghouses, and certain health care providers with respect to enforcement of the Privacy, Security, and Breach Notification Rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Based upon review of your correspondence, we have determined that OCR will not investigate your complaint. Your complaint does not contain an allegation of discrimination which would fall under any of the civil rights laws enforced by OCR. We are closing your complaint and will take no further action regarding the issue(s) you have raised.

We regret that we are unable to assist you in this matter. If you any have questions about this matter, please contact Centralized Case Management Operations at (800) 368-1019.

Sincerely yours,

Sarah C. Brown
Interim Director
Centralized Case Management Operations

English	If you speak a non-English language, call 1-800–368–1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文，请拨打1-800-368-1019（打字电话：1-800-537-7697)， 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

HEALTH INFORMATION PRIVACY COMPLAINT

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

YOUR FIRST NAME	YOUR LAST NAME
(b)(6);(b)(7)(C)	(b)(6);(b)(7)(C)
HOME / CELL PHONE (Please include area code)	WORK PHONE (Please include area code)
(b)(6);(b)(7)(C)	

STREET ADDRESS	CITY
(b)(6);(b)(7)(C)	Wilmington

STATE	ZIP	E-MAIL ADDRESS (If available)
(b)(6);(b)(7)(C)	(b)(6);(b)(7)(C)	(b)(6);(b)(7)(C)

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose health information privacy rights do you believe were violated?

FIRST NAME	LAST NAME

Who (or what agency or organization, e.g., provider, health plan) do you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule?

PERSON/AGENCY/ORGANIZATION

Planned Parenthood

STREET ADDRESS	CITY
1925 Tradd Ct	Wilmington

STATE	ZIP	PHONE (Please include area code)
North Carolina	28401	

When do you believe that the violation of health information privacy rights occurred?

LIST DATE(S)

01/20/2015

Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible. (Attach additional pages as needed)

On Tuesday 1/20/2015 prescription birth control pills were given to a Patient A. The patient completed checkout and was charged as another Patient B. Patient B's information was given to the Patient A. Possible wrong birth control pills given to Patient A.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
(b)(6);(b)(7)(C)	01/24/2015

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with health information privacy compliance and as permitted by law. It is illegal for a covered entity to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under the Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's Web site at: **www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): ____________________

☐ Foreign language interpreter (specify language): ____________________ ☐ Other: ____________________

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME / CELL PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): ____________________

PRIMARY LANGUAGE SPOKEN (if other then English) ____________________

How did you learn about the Office for Civil Rights?

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☒ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): ____________________

To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.

Region I - CT, ME, MA, NH, RI, VT	**Region V - IL, IN, MI, MN, OH, WI**	**Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions**
Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	Office for Civil Rights, DHHS 233 N. Michigan Ave. - Suite 240 Chicago, IL 60601 (312) 886-2359; (312) 353-5693 (TDD) (312) 886-1807 FAX	Office for Civil Rights, DHHS 90 7th Street, Suite 4-100 San Francisco, CA 94103 (415) 437-8310; (415) 437-8311 (TDD) (415) 437-8329 FAX
Region II - NJ, NY, PR, VI Office for Civil Rights, DHHS 26 Federal Plaza - Suite 3312 New York, NY 10278 (212) 264-3313; (212) 264-2355 (TDD) (212) 264-3039 FAX	**Region VI - AR, LA, NM, OK, TX** Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
Region III - DE, DC, MD, PA, VA, WV Office for Civil Rights, DHHS 150 S. Independence Mall West - Suite 372 Philadelphia, PA 19106-3499 (215) 861-4441; (215) 861-4440 (TDD) (215) 861-4431 FAX	**Region VII - IA, KS, MO, NE** Office for Civil Rights, DHHS 601 East 12th Street - Room 248 Kansas City, MO 64106 (816) 426-7277; (816) 426-7065 (TDD) (816) 426-3686 FAX	
Region IV - AL, FL, GA, KY, MS, NC, SC, TN Office for Civil Rights, DHHS 61 Forsyth Street, SW. - Suite 16T70 Atlanta, GA 30303-8909 (404) 562-7886; (404) 562-7884 (TDD) (404) 562-7881 FAX	**Region VIII - CO, MT, ND, SD, UT, WY** Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	**Region X - AK, ID, OR, WA** Office for Civil Rights, DHHS 701 Fifth Avenue, Suite 1600, MS - 11 Seattle, WA 98104 (206) 615-2290; (206) 615-2296 (TDD) (206) 615-2297 FAX

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: (b)(6);(b)(7)(C) Date: 01/24/2015

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): (b)(6);(b)(7)(C)

Address: (b)(6);(b)(7)(C)

Telephone Number: (b)(6);(b)(7)(C)

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act
The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 et seq.), and Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. §1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,

as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package,
Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019
TDD - (202) 619-3257
Fax - (202) 619-3818
http://www.hhs.gov/ocr

Office for Civil Rights
200 Independence Avenue, S.W.,
Room 509F
Washington, DC 20201

May 7, 2015

Attn: HIPAA Privacy Officer
Planned Parenthood – Wilmington Health Center
1921 & 1925 Wilmington Court
Wilmington, NC 28401

Re: OCR Transaction Number: 15-202141: (b)(6);(b)(7)(C) vs. Planned Parenthood

Dear HIPAA Privacy Officer:

On January 24, 2015, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received a complaint alleging that Planned Parenthood – Wilmington Health Center, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, and E, the Privacy and Security Rules). Specifically, the complainant, (b)(6);(b)(7)(C), alleges that on January 20, 2015, Planned Parenthood – Wilmington Health Center inadvertently disclosed a patient's protected health information (PHI) when the patient was given the wrong prescription. This allegation could reflect a violation of 45 C.F.R. § 164.530(c).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

In this matter, the complainant alleges that the covered entity does not employ reasonable safeguards to prevent impermissible disclosures of (PHI). A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of PHI in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure. 45 C.F.R. §164.530(c).

Pursuant to its authority under 45 C.F.R. §§ 160.304(a) and (b), OCR has determined to resolve this matter through the provision of technical assistance to Planned Parenthood – Wilmington Health Center. To that end, OCR has enclosed material explaining the Privacy Rule provisions related to Reasonable Safeguards.

You are encouraged to review these materials closely and to share them with your staff as part of the Health Insurance Portability and Accountability Act (HIPAA) training you provide to your workforce. You are also encouraged to assess and determine whether there may have been any noncompliance as alleged by the complainant in this matter, and, if so, to take the steps necessary to ensure such noncompliance does not occur in the future. In

addition, OCR encourages you to review the facts of this individual's complaint and provide the individual the appropriate written response swiftly if necessary to comply with the requirements of the Privacy Rule. Should OCR receive a similar allegation of noncompliance against Planned Parenthood – Wilmington Health Center in the future, OCR may initiate an investigation of that matter. In addition, please note that, after a period of six months has passed, OCR may initiate and conduct a compliance review of Planned Parenthood – Wilmington Health Center related to your compliance with the Privacy Rule's provisions related to Reasonable Safeguards.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If you have any questions regarding this matter, please contact Jessica Allen, Investigator, at (202) 260-6017 (Voice) or (202) 619-3257 (TDD).

Sincerely,

Kurt T. Temple
Associate Deputy Director for Regional Operations

Enclosure: Reasonable Safeguards

Reasonable Safeguards

45 C.F.R. § 164.530 (c)

A covered entity must have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures not permitted by the Privacy Rule, as well as that limit incidental uses or disclosures. See 45 C.F.R. §164.530 (c). It is not expected that a covered entity's safeguards guarantee the privacy of protected health information from any and all potential risks. Reasonable safeguards will vary from covered entity to covered entity depending on factors, such as the size of the covered entity and the nature of its business. In implementing reasonable safeguards, covered entities should analyze their own needs and circumstances, such as the nature of the protected health information it holds, and assess the potential risks to patients' privacy. Covered entities should also take into account the potential effects on patient care and may consider other issues, such as the financial and administrative burden of implementing particular safeguards.

Many health care providers and professionals have long made it a practice to ensure reasonable safeguards for individuals' health information – for instance:

- By speaking quietly when discussing a patient's condition with family members in a waiting room or other public area;
- By avoiding using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality;
- By isolating or locking file cabinets or records rooms; or
- By providing additional security, such as passwords, on computers maintaining personal information.

Protection of patient confidentiality is an important practice for many health care and health information management professionals; covered entities can build upon those codes of conduct to develop the reasonable safeguards required by the Privacy Rule.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019
TDD - (202) 619-3257
Fax - (202) 619-3818
http://www.hhs.gov/ocr

Office for Civil Rights
200 Independence Avenue, S.W.,
Room 509F
Washington, DC 20201

May 7, 2015

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: 15-202141: (b)(6);(b)(7)(C) vs. Planned Parenthood

Dear (b)(6);(b)(7)(C):

On January 24, 2015, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received your complaint alleging that Planned Parenthood – Wilmington Health Center, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, and E, the Privacy and Security Rules). Specifically, you allege that on January 20, 2015, Planned Parenthood – Wilmington Health Center inadvertently disclosed a patient's protected health information (PHI) when the patient was given the wrong prescription. This allegation could reflect a violation of 45 C.F.R. § 164.530(c).

Thank you for bringing this matter to OCR's attention. Your complaint is an integral part of OCR's enforcement efforts.

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of (PHI) in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure. 45 C.F.R. §164.530(c). For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes.

We have carefully reviewed your complaint against Planned Parenthood – Wilmington Health Center and have determined to resolve this matter through the provision of technical assistance to Planned Parenthood – Wilmington Health Center. Should OCR receive a similar allegation of noncompliance against Planned Parenthood – Wilmington Health Center in the future, OCR may initiate an investigation of that matter.

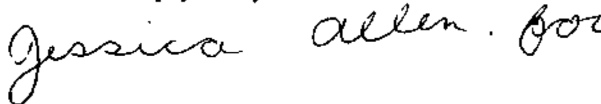
For your informational purposes, OCR has enclosed material regarding the Privacy Rule provisions related to Safeguards.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If you have any questions about this matter, please contact Centralized Case Management Operations at (800) 368-1019 or (202) 619-3257 (TDD).

Sincerely yours,



Kurt T. Temple
Associate Deputy Director for Regional Operations

Enclosure: Reasonable Safeguards

English	If you speak a non-English language, call 1-800–368–1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文，请拨打1-800-368-1019（打字电话：1-800-537-7697)，你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.

Reasonable Safeguards

45 C.F.R. § 164.530 (c)

A covered entity must have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures not permitted by the Privacy Rule, as well as that limit incidental uses or disclosures. See 45 C.F.R. §164.530 (c). It is not expected that a covered entity's safeguards guarantee the privacy of protected health information from any and all potential risks. Reasonable safeguards will vary from covered entity to covered entity depending on factors, such as the size of the covered entity and the nature of its business. In implementing reasonable safeguards, covered entities should analyze their own needs and circumstances, such as the nature of the protected health information it holds, and assess the potential risks to patients' privacy. Covered entities should also take into account the potential effects on patient care and may consider other issues, such as the financial and administrative burden of implementing particular safeguards.

Many health care providers and professionals have long made it a practice to ensure reasonable safeguards for individuals' health information – for instance:

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- By avoiding using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality;
- By isolating or locking file cabinets or records rooms; or
- By providing additional security, such as passwords, on computers maintaining personal information.

Protection of patient confidentiality is an important practice for many health care and health information management professionals; covered entities can build upon those codes of conduct to develop the reasonable safeguards required by the Privacy Rule.

Dear Ms. Reisz:

I will note the file that I gave Planned Parenthood an extension until Friday, March 13, 2015.

Thank you.

Investigator Hilden
Office for Civil Rights, Region V
Telephone: (312) 353-9688
Fax: (312) 886-1807

This E-mail, along with any attachments, is considered confidential. If you have received it in error, you are on notice of its status. Please notify us immediately by reply e-mail and then delete this message from your system. Please do not copy it or use it for any purposes, or disclose its contents to any other person. Thank you for your cooperation.

From: Reisz, Lisa Pierce [mailto:LPReisz@vorys.com]
Sent: Wednesday, March 04, 2015 12:33 PM
To: Hilden, Alyce (HHS/OCR)
Subject: Planned Parenthood -- OCR Transaction Number 15-203300

Good afternoon Ms. Hilden,
Thanks so much for your message yesterday regarding the posting of Planned Parenthood's incident on the OCR website (and its potential removal pending your investigation). I appreciate your looking into that issue and your phone call explaining the status. Planned Parenthood is working on a response to your February 23, 2015 letter. By my calculation, Planned Parenthood's response is due on Monday, March 9, 2015. I am writing to request a brief extension of time to respond until Friday, March 13, 2015. The Executive Director of Planned Parenthood is out of state this week, and does not return until next week. A few additional days will allow him the chance to review and approve the response. Could you let me know if an extension until March 13, 2015 is okay?
Thanks.
Lisa

Lisa Pierce Reisz
Partner

Vorys, Sater, Seymour
and Pease LLP
52 East Gay Street |
Columbus, Ohio 43215

Direct: 614.464.8353
Fax: 614.719-4919
Email:
lpreisz@vorys.com
www.vorys.com

From the law offices of Vorys, Sater, Seymour and Pease LLP.

CONFIDENTIALITY NOTICE: This e-mail message may contain confidential and/or

privileged material. Any
unauthorized review, use,
disclosure or
distribution is prohibited. If
you are not the intended
recipient, please
contact the sender by reply e-
mail and destroy all copies of
the original
message. If you are the intended
recipient but do not wish to
receive
communications through this
medium, please so advise the
sender immediately.

HITECH Breach Report for the Office for Civil Rights

Name: PPSWO

Breach Tracking No: (b)(5)

Breach Affecting: 500 or More Individuals
Report Type: Initial Breach Report

CE Address: 2314 Auburn Ave
CE City: Cincinnati
CE State: OH
CE Zip: 45219

CE Contact Name: (b)(6);(b)(7)(C)
CE Phone: (b)(6);(b)(7)(C)
CE Email: (b)(6);(b)(7)(C)
CE Type: Healthcare Provider

BA Name:

BA Address:
BA City:
BA State:
BA Zip:

BA Contact Name:
BA Phone:
BA Email:

Breach Start Date: 10/01/2014
Discovery Start Date: 10/03/2014
Approximate # of Individuals Affected by the Breach: 5000

Breach End Date: 10/02/2014
Discovery End Date: 10/03/2014

Type of Breach: Improper Disposal
Location of Breached Information: Paper/Films
Type of PHI Involved in the Breach: Clinical, Demographic

Demographic: Date of Birth, Name
Financial:
Clinical: Lab Results, Medications

Type of Breach (other):

Location of Breached Information (other):

Type of PHI Involved in the Breach (other):

Brief Description of the Breach: Health Center Manager discovered a shelf used for archiving prescription logs and waived lab test logs was empty and reported the problem to the privacy officer. The privacy officer investigated the situation which uncovered that the storage location of the logs was left un-locked after hours and their long time custodian accidently removed the logs, put them in a trash bag, and put them in the dumpster (on private property, under video surveillance) due to a miscommunication on items that needed to be removed (bulk trash). Video surveillance showed no trespassers accessed the logs in the dumpster until the following morning when the dumpster was emptied by the trash collector. Trash collector verified that the contents of the dumpster would have been compressed, mixed with other garbage, and then buried under additional loads at the landfill within the same day. After a careful risk assessment was conducted and receiving advice from legal counsel, the privacy officer and CEO determined that their was a very low probability of compromised PHI and concluded that notification is not required based on the facts of this particular situation. Detailed records have been maintained to reflect the results of the investigation, legal advice, risk assessment, final determination, and the details of the corrective action plan put in place as a result of the incident.

Safeguards: Privacy Rule Safeguards (Training, Policies and Procedures, etc.), Security Rule Administrative Safeguards (Risk Analysis, Risk Management, etc.), Security Rule Physical Safeguards (Facility Access Controls, Workstation Security, etc.), Security Rule Technical Safeguards (Access Controls, Transmission Security, etc.)

Notice Start Date: 11/20/2014
Substitute: No
10 or more: No

Notice End Date:
Media No
Media States:

Action Response: Implemented new technical safeguards, Improved physical security, Revised policies and procedures, Sanctioned workforce members involved (including termination), Took steps to mitigate harm, Trained or retrained workforce members

Action Description:

Signature Name: (b)(6);(b)(7)(C)
Signature Date: 02/05/2015

This report from the Department of Health and Human Services, Office for Civil Rights contains information that is PRIVILEGED and CONFIDENTIAL. You are hereby notified that any dissemination of this message is strictly prohibited. If you have received this report in error, please do not read, copy or forward and permanently delete all copies.

Wednesday, April 06, 2011

DEPARTMENT OF HEALTH & HUMAN SERVICES
Voice - (312) 886-2359
TDD - (312) 353-5693
(FAX) - (312) 886-1807
http://www.hhs.gov/ocr/

OFFICE OF THE SECRETARY
Office for Civil Rights, Region V
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

February 23, 2015

(b)(6);(b)(7)(C)
Planned Parenthood
of Southwest Ohio
2314 Auburn Ave.
Cincinnati, OH 45219

Re: Planned Parenthood of Southwest Ohio Breach
OCR Transaction Number: 15-203300

Dear (b)(6);(b)(7)(C)

Please be advised that, on February 5, 2015, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) received a breach notification report, required by 45 C.F.R. § 164.408, from Planned Parenthood of Southwest Ohio (PPSWO). Based on this breach notification report, OCR is investigating whether PPSWO is in compliance with the applicable Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, and E, the Privacy and Security Rules), and the Breach Notification Rule (45 C.F.R. Parts 160 and 164, Subpart D).

The breach notification report indicates that, on October 1, 2014, PPSWO's storage location for its archiving prescription logs and waived lab test logs was left unlocked after business hours. According to PPSWO, a custodian mistakenly put these logs in a trash bag and then in the dumpster. The following morning, the dumpster was emptied by the trash collector who took it to be buried with other garbage at the landfill that same day. The information contained in the logs included names, dates of birth, lab results, and medications. This breach affected approximately 5,000 individuals. The information reported by PPSWO indicates potential violations of 45 C.F.R. §§ 164.502(a), 164.530(c), 164.404(a), 164.406(a), and 164.408(b).

OCR enforces the Privacy and Security Rules, and the Breach Notification Rule. OCR also enforces Federal civil rights laws that prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and, under certain circumstances, sex, and religion.

OCR is responsible for enforcing the Privacy and Security Rules, and the Breach Notification Rule, as those Rules apply to "covered entities" and "business associates." Covered entities are health care clearinghouses, health plans, and health care providers that transmit health information in electronic form in connection with a transaction for which HHS has adopted standards. See 45 C.F.R. Part 162. Business associates are persons or entities that provide certain services to or perform functions on behalf of covered entities, or other business associates of covered entities, that require access to protected health information.

OCR's enforcement authority is codified at 45 C.F.R. Part 160, Subparts C, D, and E (the Enforcement Rule), which relates to compliance with, and enforcement of, each of the above-referenced Rules. The Enforcement Rule requires that covered entities and business associates cooperate with OCR during an investigation or compliance review of a covered entity's or business associate's policies, procedures, or practices to determine whether it is complying with the applicable provisions. 45 C.F.R. § 160.310(b). It also requires that covered entities and business associates permit OCR access to its facilities, records and other information during normal business hours or at any time, without notice, if exigent circumstances exist. 45 C.F.R. § 160.310(c).

Please contact the OCR Investigator named below **immediately upon receipt of this letter** to discuss this matter. In addition, please submit your responses to the enclosed data request **within 14 days of the date of this letter**, and number each response to correspond with the number and letter in the data request. Be sure to produce the documents in compliance with the "Instructions" set forth below, including the placement of consecutive bates numbers on the documents.

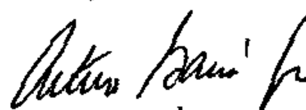
A covered entity or business associate has the right to submit additional data beyond that requested by OCR in the data request, as the covered entity or business associate deems appropriate. Such data could pertain to the covered entity's or business associate's compliance with the applicable provisions of the Privacy, Security, and Breach Notification Rules and/or pertain to the actions the covered entity or business associate has taken to correct the noncompliance.

If we are unable to resolve this matter voluntarily, and if OCR's investigation results in a finding that PPSWO has failed to comply with the applicable provisions of the Privacy and Security Rules and/or the Breach Notification Rule, HHS may initiate formal enforcement action which may result in the imposition of civil money penalties, or take other actions consistent with OCR's jurisdiction. We have enclosed a separate fact sheet explaining the penalty provisions under the Privacy, Security, and Breach Notification Rules. The fact sheet also explains that certain violations of the Privacy and Security Rules may be subject to criminal penalties, which the U.S. Department of Justice is responsible for enforcing.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy. OCR will also attempt to protect information from disclosure that is submitted by PPSWO in response to this or other data requests if such information constitutes "proprietary information" for purposes of the Freedom of Information Act and/or HHS's implementing regulations.

If you have any questions, please do not hesitate to contact Alyce Hilden, OCR Investigator, at 312-353-9688 (Voice), 312-353-5693 (TDD), or at Alyce.Hilden@hhs.gov. When contacting this office, please remember to include the transaction number that we have given this file. That number is located in the reference line of this letter.

Sincerely,



Celeste H. Davis
Regional Manager

Enclosures: Data Request
The Privacy and Security Rules Enforcement and Penalty Provisions Fact Sheet

Planned Parenthood of Southwest Ohio Breach
OCR Transaction Number: 15-203300

DATA REQUEST

1. The name, title, and telephone number of the individual designated to work with OCR during the subject investigation.
2. A detailed position statement explaining the breach and steps taken in response to the breach. Include any supporting and relevant documentation with your submission.
3. The names and contact information of the people who made the determination that there was a low probability of compromised PHI and thus concluded that notification was not required.
4. OCR noticed that this breach was filed beyond 60 days following the discovery of the breach (see 45 C.F.R. § 164.408 – Notification to the Secretary). Please explain why the breach filing was untimely.
5. Evidence of how you know that the logs were buried in the landfill and that the breached was not compromised.
6. A copy of your policies and procedures related to uses and disclosures of protected health information. 45 C.F.R. § 164.502(a).
7. A copy of your policies and procedures related to safeguarding protected health information. 45 C.F.R. § 164.530(c)(1).
8. A copy of the notification of the breach sent, as required by 45 C.F.R. § 164.404, to the individuals whose unsecured PHI has been, or is reasonably believed by you to have been, accessed, acquired, used, or disclosed as a result of the breach. If notification was not sent, please explain.
9. A copy of the notification of the breach sent to the media as required by 45 C.F.R. § 164.406. If notification was not sent, please explain.
10. Evidence of any actions taken to determine the root cause of the underlying disclosure (Privacy and/or Security actions).
11. A copy of the risk analysis performed for or by PPSWO prior to the incident and any conducted after the incident as well as mitigation to threats identified in the risk analysis. 45 C.F.R. § 164.308(a)(1)(ii)(A) & (B) - Risk Analysis/Management (Required).
12. A copy of PPSWO's corrective action plan.

THE PRIVACY, SECURITY, AND BREACH NOTIFICATION RULES ENFORCEMENT AND PENALTIES FOR NONCOMPLIANCE

The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) and the Security Standards for the Protection of Electronic Protected Health Information (Security Rule) establish a set of national standards for the use, disclosure, and safeguarding of an individual's health information – called protected health information – by covered entities and business associates. The Privacy Rule sets standards for the use and disclosure of protected health information by covered entities and business associates and also sets standards for providing individuals with privacy rights to understand and control how their health information is used and disclosed. The Security Rule's standards specify a series of administrative, technical, and physical security procedures for covered entities and business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information. The Breach Notification Rule's standards require covered entities and business associates to provide notification following a breach of unsecured protected health information. The Department of Health and Human Services, Office for Civil Rights (OCR) is responsible for administering and enforcing these standards and may conduct complaint investigations and compliance reviews.

Consistent with the principles for achieving compliance provided in the Privacy, Security, and Breach Notification Rules, OCR will seek the cooperation of covered entities and business associates and may provide technical assistance to help them comply voluntarily with the applicable provisions of the Privacy,Security, and Breach Notification Rules. Covered entities and business associates that fail to comply voluntarily with the applicable standards may be subject to civil money penalties. In addition, certain violations of the Privacy, Security, and Breach Notification Rules may be subject to criminal prosecution. These penalty provisions are explained below.

Civil Money Penalties. OCR may impose a penalty on a covered entity or business associate for a failure to comply with an applicable requirement of the Privacy, Security, or Breach Notification Rule. Penalties will vary significantly depending on factors such as the date of the violation, whether the covered entity or business associate knew or should have known of the failure to comply, or whether the covered entity's or business associate's failure to comply was due to willful neglect. Penalties may not exceed a calendar year cap for multiple violations of the same requirement.

For violations occurring on or after February 18, 2009, OCR may impose penalties of $100 to $50,000 or more per violation with a calendar year cap of $1,500,000. A penalty may not be imposed for violations in certain circumstances, such as if the covered entity or business associate establishes to the satisfaction of OCR that:

- the failure to comply was not due to willful neglect, and
- the failure to comply was corrected during a 30-day period after the entity knew or should have known the failure to comply had occurred (unless the period is extended at the discretion of OCR).

In addition, OCR may choose to reduce a penalty if the failure to comply was due to reasonable cause and the penalty would be excessive given the nature and extent of the noncompliance.

Before OCR imposes a penalty, it will notify the covered entity or business associate and provide the covered entity or business associate with an opportunity to provide written evidence of those circumstances that would reduce or bar a penalty. This evidence must be submitted to OCR within 30 days of receipt of the notice. In addition, if OCR states that it intends to impose a penalty, a covered entity or business associate has the right to request an administrative hearing to appeal the proposed penalty.

Criminal Penalties. A person who knowingly obtains or discloses individually identifiable health information in violation of the Privacy and Security Rules may face a criminal penalty of up to $50,000 and up to one-year imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to 10 years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain or malicious harm. The Department of Justice is responsible for criminal prosecutions under the Privacy and Security Rules.

Hilden, Alyce (HHS/OCR)

From: Reisz, Lisa Pierce <LPReisz@vorys.com>
Sent: Friday, March 13, 2015 3:34 PM
To: Hilden, Alyce (HHS/OCR)
Cc: (b)(6);(b)(7)(C)
Subject: Planned Parenthood Southwest Ohio Region; OCR Transaction No.: 15-203300
Attachments: letter.pdf; 1.pdf

Ms. Hilden,
Attached please find a copy of Planned Parenthood of Southwest Ohio Region's response to OCR's letter of February 23, 2015, and its supporting documentation. A hard-copy of these documents is being sent to you today by overnight carrier for delivery on Monday. If you have any questions or need any additional information, please do not hesitate to contact me.
Regards,
Lisa

VORYS
Legal Counsel

Lisa Pierce Reisz
Partner

Vorys, Sater, Seymour
and Pease LLP
52 East Gay Street |
Columbus, Ohio 43215

Direct: 614.464.8353
Fax: 614.719-4919
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lpreisz@vorys.com
www.vorys.com

From the law offices of Vorys, Sater, Seymour and Pease LLP.

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VORYS

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Founded 1909

Lisa Pierce Reisz
Direct Dial (614) 464-8353
Direct Fax (614) 719-4919
Email lpreisz@vorys.com

March 13, 2015

VIA OVERNIGHT CARRIER AND E-MAIL

Ms. Alyce Hilden
Investigator
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Re: Planned Parenthood Southwest Ohio Region
OCR Transaction No.: 15-203300

Dear Ms. Hilden:

On behalf of our client, Planned Parenthood Southwest Ohio Region ("PPSWO"), I write to respond to OCR's letter of February 23, 2015, regarding the October 2, 2014 incident ("the Incident") involving the disposal of certain binders containing protected health information ("PHI") from Planned Parenthood's Elizabeth Campbell Center, located at 2314 Auburn Avenue, Cincinnati, Ohio 45219.

PPSWO is committed to protecting the confidentiality and security of its patients' health information. At the time of the Incident, PPSWO had adopted and implemented HIPAA Privacy and Security policies and procedures, had trained its staff on these policies and procedures, and had responded to the Incident pursuant to these policies and procedures. Since the Incident, PPSWO has implemented additional measures and training to ensure the privacy and security of its patient information and to strengthen its HIPAA compliance efforts. Specifically, PPSWO has re-trained staff regarding the importance of securing all PHI at the end of each day to prevent any unauthorized access. PPSWO has also implemented a new bulk trash policy to ensure no further confusion with the cleaning staff about any bulk trash items.

PPSWO respectfully submits this position statement in response to OCR's breach inquiry.

PPSWO's Position Statement

PPSWO is the leading reproductive health care provider, educator and advocate for the Southwest Ohio and Northern Kentucky communities. PPSWO has seven health centers

that provide a wide range of reproductive health care services to these communities. The Elizabeth Campbell Center ("the Center") is one of PPSWO's family planning centers.

The October 2, 2014 Incident

On October 3, 2014, the Center's Manager discovered that several binders containing PHI were missing from a closet that was used for on-site archiving of certain paper logs at the Center. These logs included (1) waived test lab logs from April 1, 2014 to September 19, 2014, which contained names, dates of birth, dates of service, and test results; and (2) prescription dispensing logs from 2009-2013, which contained names, dates of birth, dates of service, and prescriptions dispensed. PPSWO estimates that the health information of at least 5000 patients could have been in these binders.

PPSWO immediately began an investigation into the missing binders.

During this investigation, the Director of Facilities-Security confirmed with PPSWO's cleaning company, Corvus Janitorial Services,[1] that the missing binders had been removed from the closet as trash and taken to the dumpster in the Center's back parking lot by one of Corvus' long-time custodians at approximately 11:00 p.m. on October 2, 2014. The custodian explained that he had removed the binders from the closet because there was a hand-written note near the binders that said "TRASH," and he assumed that the binders were to be removed as similar signs in the past had been used to notify the cleaning crew of bulk trash that was to be taken to the dumpster.[2] The custodian also said that after placing the binders in the dumpster, he covered them with several plastic bags full of PPSWO's trash.

The Director of Facilities-Security's investigation also confirmed that the trash from the PPSWO dumpster was picked up by a Rumpke trash truck at 6:00 a.m. on October 3, 2014 (early the next morning). Rumpke also confirmed that once the contents of the dumpster were in the Rumpke truck, they would have been ground and destroyed by the compressors in the truck and then buried under tons of other garbage at the landfill. Rumpke stated that there would be no reasonable means to recover the documents.

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[1] Corvus Janitorial Services, which has been PPSWO's cleaning vendor since 2007, is a business associate of PPSWO. A copy of the business associate agreement between PPSWO and Corvus is attached hereto as Exhibit A.
[2] Although PPSWO is not sure how the "TRASH" sign was placed near the binders, PPSWO was able to confirm that an area right outside of the closet had been designated for bulk trash removal in connection with the conversion of an operating room into a centralized follow up work room. The "TRASH" sign may have been stuck on the wall and somehow it was moved onto the shelf in the closet with the binders.

Finally, the Director of Facilities-Security inspected the dumpster and parking lot on the morning that the binders were found to be missing, and found the dumpster lid closed, observed that no dumpster contents were scattered outside the dumpster, and determined that there was no sign that any intruder had been inside the dumpster. In addition, the Director of Facilities-Security reviewed approximately 2-3 hours of the video surveillance tape from the security cameras monitoring the PPSWO parking lot and dumpster on the night of October 2-3, 2014. Based on his physical analysis of the dumpster and parking lot the morning after the binders went missing as well as his review of the security videotape, the Director of Facilities-Security concluded that there was no sign that any intruder had been inside or even near the dumpster that night.

PPSWO HIPAA Breach Analysis

Following PPSWO's investigation into this incident, PPSWO, with the assistance and guidance of legal counsel, conducted a four-factor HIPAA breach risk assessment pursuant to 45 C.F.R. § 164.402. See PPSWO HIPAA Breach Risk Assessment (Nov. 21, 2014)(attached hereto as Exhibit B). This analysis, which was dated November 21, 2014, is set forth below:

PPSWO Risk Assessment:

- The nature and extent of PHI involved, including the types of identifiers and the likelihood of re-identification:
    - The types of PHI involved included the patients first and last name, date of birth, date of service, waived test lab result (either pregnancy test, urinalysis, hemoglobin count, or rapid HIV), or prescription medication dispensed to the patient during their visit. No financial information was on the logs.
- The unauthorized person who used the PHI or to whom the disclosure was made:
    - No one obtained the information. If the custodian was exposed to the PHI it may be considered under the category of "incidental exposure." Video surveillance confirmed that no other unauthorized person accessed the information before the trash truck's arrival.[3] Once the Rumpke truck picked up the contents of the

[3]To clarify, the PPSWO Director of Facilities-Security reviewed approximately 2-3 hours of the security video of the PPSWO parking lot and dumpster from the night of October 2, 2014 – the night the cleaning crew placed the binders in the dumpster. Video was not available for the entire time period between the time the cleaning crew placed the binders in the dumpster (at approximately 11:00 p.m) and the time that Rumpke emptied the dumpster, crushed its contents, and disposed of it in the landfill (at approximately 6:00 a.m.) since portions of the tape had already been recorded over by the time the Director of Facilities-Security requested the full tape for review a few days later. See PPSWO Quality and Risk Management Action Plan Supplemental Incident Report related to 10/3/14 Incident (Feb. 28, 2015)(attached hereto as Exhibit C).

dumpster, the PHI would have been crushed, mixed with other garbage, and buried subsequently at the landfill. The probability would be extremely low that the PHI was in any form that would carry the potential for disclosure to any person.

- Whether the PHI was actually acquired or viewed:
  - Based on the sequence of events uncovered during the investigation, PPSWO has determined the PHI was not acquired or viewed, outside of the incidental exposure of the custodian.
- The extent to which the risk to the PHI has been mitigated:
  - Upon the report being made of the binders being missing, PPSWO took immediate steps to investigate the facts and determine what could be done to mitigate the risk of the unsecured PHI being acquired or viewed further. The final determination was that the documents were destroyed by the trash truck and concluded that they were unrecoverable at the landfill, thus eliminating the risk of the PHI being disclosed.

As a result of this four-factor analysis, PPSWO determined that there was a low probability of compromise of the PHI at issue. Therefore, PPSWO determined that this incident was **not** a reportable breach under HIPAA. Thus, no notifications were sent to individuals, OCR or the media.

PPSWO's Remediation Plan

Notwithstanding PPSWO's determination that there was no reportable breach, PPSWO's HIPAA Privacy Officer and HIPAA Security Officer met to discuss the incident, review its root cause, and to recommend changes in PPSWO's policies and procedures to prevent any future incidents involving the improper storage and disposal of patient information.

In investigating this incident, PPSWO's HIPAA Privacy Officer determined that the Center's Manager had placed the binders in the Center's closet (which had shelves and had previously been used to store other binders) because she no longer had room elsewhere to store them, and did not understand that the binders contained PHI. In response to these findings, the Center no longer stores any PHI in this closet, and PPSWO undertook an organization-wide re-training to ensure that all PHI is properly secured.

In addition, PPSWO implemented the following corrective action plan:

1. PPSWO's HIPAA Privacy Officer and HIPAA Security Officer conducted a HIPAA compliance training at each health center location (including the Elizabeth Campbell Center) to re-train all staff regarding PPSWO's HIPAAA policies and procedures, including PPSWO's policy requiring that all documents

containing PHI be securely locked up at the end of each business day to prevent any unauthorized access to this information. A copy of the training schedule and agenda is attached hereto as Exhibit D.

2. While on site for these trainings, the HIPAA Privacy Officer and HIPAA Security Officer conducted an on-site HIPAA compliance audit to identify any other areas of concern related to the privacy and security of PHI. All areas of concern were timely addressed.

3. The Director of Facilities-Security implemented a new policy to address bulk trash removal from the health centers in October 2014. This policy was implemented at the Center in December 2014, and has been rolled out to PPSWO's other facilities over the past month. This policy requires notification of the Director of Facilities-Security of the need for bulk trash removal and an authorized sign which must be taped to the items to be removed. See Bulk Trash at Center Policy (and a copy of "TRASH" sign) (attached hereto as Exhibit E).

OCR's Data Request

Finally, PPSWO responds to your February 23, 2105 Data Request as follows:

1. Provide the name, title and telephone number of the individual designated to work with OCR during the subject investigation.

Response:

Lisa Pierce Reisz
Counsel
(614) 464-8353
lpreisz@vorys.com

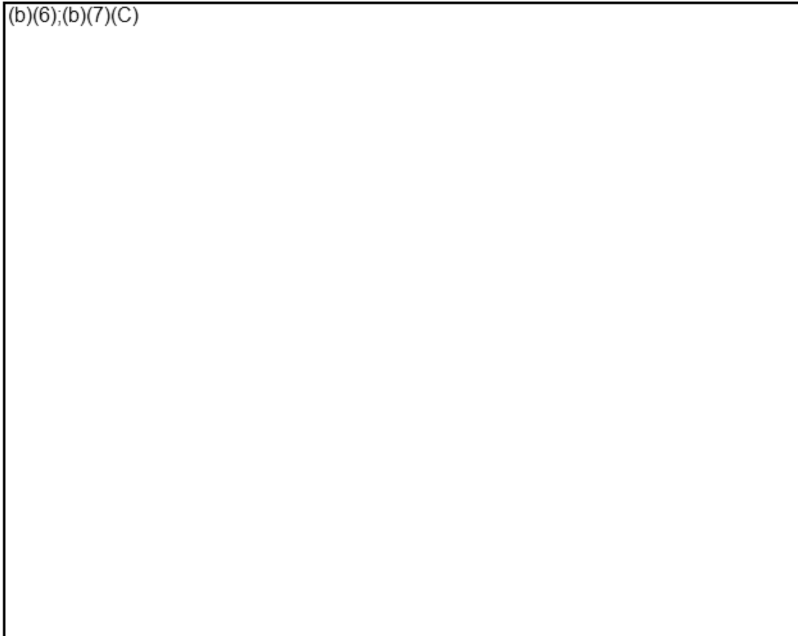
2. A detailed position statement explaining the breach and steps taken in response to the breach. Include any supporting and relevant documentation with your submission.

Response:

See above.

3. The names and contact information of the people who made the determination that there was a low probability of compromised PHI and thus concluded that notification was not required.

Response:


(b)(6);(b)(7)(C)

4. OCR noticed that this breach was filed beyond 60 days following the discovery of the breach (see 45 C.F.R. § 164.408 – Notification to the Secretary). Please explain why the breach filing was untimely.

Response:

PPSWO respectfully disagrees with OCR's characterization that this incident is a "breach" or that PPSWO's filing was untimely. After concluding its investigation into the Incident, PPSWO performed HIPAA's four-factor breach assessment and concluded that there was a low probability that the PHI in the binders had been compromised. See PPSWO HIPAA Breach Risk Assessment (Nov. 21, 2014)(Exhibit B). As a result, the Incident was not a reportable breach under HIPAA. Thus, PPSWO's February 5, 2015 "breach filing" to OCR was not untimely, but was simply made in error. No such report to OCR was required given PPSWO's analysis and conclusion that there was no reportable breach.

5. Evidence of how you know that the logs were buried in the landfill and that the breached (sp) was not compromised.

Response:

PPSWO thoroughly investigated this incident and determined that the binders containing the test waiver logs and prescription logs were picked up by a Rumpke trash truck at 6:00 a.m. on October 3, 2015, compressed in the trucks, and dumped in the landfill. Evidence in support of this conclusion includes:

- **The cleaning crew confirmed that they placed the binders in the PPSWO dumpster at approximately 11:00 p.m. on October 2, 2014, and then placed multiple plastic bags of trash on top of the binders in the dumpster that evening.**

- **Rumpke confirmed that the contents of the PPSWO dumpster were emptied into a Rumpke truck at 6:00 a.m. on October 3, 2014, were then compressed in the Rumpke truck, and then dumped into the landfill. Rumpke confirmed that these documents, once in the landfill, were no longer reasonably accessible.**

- **PPSWO's Director of Facilities-Security inspected the dumpster and parking lot on the morning that the binders were found to be missing, and found the dumpster lid closed, observed that no dumpster contents were scattered outside the dumpster, and determined that there was no sign that any intruder had been inside the dumpster. In addition, the Director of Facilities-Security reviewed 2-3 hours of video surveillance tape from the security cameras monitoring the PPSWO parking lot and dumpster on the night of October 2-3, 2014. Based on his physical analysis of the dumpster and parking lot the morning after the binders went missing as well as his review of the security videotape, the Director of Facilities-Security concluded that there was no sign that any intruder had been inside or even near the dumpster that night.**

6. A copy of your policies and procedures related to uses and disclosures of protected health information. 45 C.F.R. § 164.502(a).

Response:

A copy of PPSWO's HIPAA Privacy Manual, Second Edition (revised September 23, 2013), is attached hereto as Exhibit F.

7. A copy of your policies and procedures related to safeguarding protected health information. 45 C.F.R. § 530(c)(1).

Response:

A copy of PPSWO's HIPAA Privacy Manual, Second Edition (revised September 23, 2013), is attached hereto. (Exhibit F).

8. A copy of the notification of the breach sent, as required by 45 C.F.R. § 164.404, to the individuals whose unsecured PHI has been, or is reasonably believed by you to have been, accessed, acquired, used, or disclosed as a result of the breach. If notification was not sent, please explain.

Response:

PPSWO respectfully disagrees with OCR's characterization that this incident is a "breach." On November 21, 2014, after concluding its investigation into the Incident, PPSWO performed HIPAA's four-factor breach assessment and concluded that there was a low probability that the PHI in the binders had been compromised. See PPSWO HIPAA Breach Risk Assessment (Nov. 21, 2014)(Exhibit B). As a result, this incident was not a reportable breach under HIPAA. Therefore, no notification was sent to any individuals under 45 C.F.R. § 164.404.

9. A copy of the notification of the breach sent to the media as required by 45 C.F.R. § 164.406. If notification was not sent, please explain.

Response:

PPSWO respectfully disagrees with OCR's characterization that this incident is a "breach." On November 21, 2014, after concluding its investigation into the Incident, PPSWO performed HIPAA's four-factor breach assessment and concluded that there was a low probability that the PHI in the binders had been compromised. See PPSWO HIPAA Breach Risk Assessment (Nov. 21, 2014)(Exhibit B). As a result, this incident was not a reportable breach under HIPAA. Therefore, no notification was sent to the media under 45 C.F.R. § 164.406.

10. Evidence of any actions taken to determine the root cause of the underlying disclosure (Privacy and/or Security actions).

<u>Response:</u>

Following the Incident, PPSWO's HIPAA Privacy Officer and HIPAA Security Officer met to discuss the Incident, review its root cause, and recommend changes in PPSWO's policies and procedures to prevent any future incidents involving the improper storage and disposal of patient information.

In investigating the Incident, PPSWO's HIPAA Privacy Officer determined that the Center's Manager had placed the binders in the Center's closet (which had shelves and had previously been used to store other binders) because she no longer had room elsewhere to store them, and did not understand that the binders contained PHI. In response to these findings, the Center no longer stores any PHI in this closet, and PPSWO undertook an organization-wide re-training effort to ensure that all PHI is properly secured.

In addition, PPSWO implemented the following corrective action plan:

- **PPSWO's HIPAA Privacy Officer and HIPAA Security Officer conducted a HIPAA compliance training at each health center location (including the Elizabeth Campbell Center) to train all staff regarding PPSWO's policy requiring that all documents containing PHI be securely locked up at the end of each business day to prevent any unauthorized access to this information. <u>See</u> Training Materials and Agenda (Exhibit D).**

- **While on site for these trainings, the HIPAA Privacy Officer and HIPAA Security Officer conducted an on-site HIPAA compliance audit to identify any other areas of concern related to the privacy and security of PHI. All areas of concern were timely addressed.**

- **The Director of Facilities-Security implemented a new policy to address bulk trash removal from the health centers in October 2014. This policy was implemented at the Center in December 2014, and has been rolled out to PPSWO's other facilities over the past month. This policy requires notification of the Director of Facilities-Security of the need for bulk trash removal and an authorized sign which must be taped to the items to be removed. <u>See</u> Bulk Trash at Center Policy (Exhibit E),**

11. A copy of the risk analysis performed for or by PPSWO prior to the incident and any conducted after the incident as well as mitigation to threats identified in the risk analysis. 45 C.F.R. § 164.308(a)(1)(ii)(A)&(B) – Risk Analysis/Management (Required).

Response:

A copy of PPSWO's HIPAA Risk Assessment Audit (December 17, 2013) is attached hereto as Exhibit G.

12. A copy of PPSWO's corrective action plan.

Response:

A copy of PPSWO's Corrective Action Plan (November 21, 2014) is attached hereto as Exhibit B.

If you have any questions regarding this position statement or would like any additional information, please do not hesitate to contact me.

Very truly yours,

(b)(6);(b)(7)(C)

(b)(6);(b)(7)(C)

Enclosure

cc: (b)(6);(b)(7)(C)

Page 0445 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0446 of 1306

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of the Freedom of Information Act

Page 0447 of 1306

Withheld pursuant to exemption

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Page 0448 of 1306

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Page 0449 of 1306

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Page 0450 of 1306

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Page 0451 of 1306

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Page 0452 of 1306

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Page 0453 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0454 of 1306

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of the Freedom of Information Act

Page 0455 of 1306

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of the Freedom of Information Act

Page 0456 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

D

PLANNED PARENTHOOD SOUTHWEST OHIO REGION
IN-SERVICE/TRAINING LOG

DATE:	1/13/15
TOPIC:	HIPAA Compliance Training
LOCATION:	Hamilton
TIME:	10am
PRESENTER(S):	(b)(6);(b)(7)(C)
INSERVICE/TRAINING SESSION TOPIC SUMMARY:	Review the importance of following HIPAA regulations and PPSWO HIPAA Privacy and Security policies and procedures to prevent the risk of violations.

PARTICIPANT INFORMATION

NAME	TITLE	CENTER(S) WHERE EMPLOYED	SIGNATURE
(b)(6);(b)(7)(C)	L.P.N.	Hamilton	(b)(6);(b)(7)(C)
	APRN	Ham	
	LPN	Ham	
	HCA	HAM	
	HCM	HAM	
	HCA	Ham	
	Dir. QRM	all	
	Dir - IT	all	

PLANNED PARENTHOOD SOUTHWEST OHIO REGION
IN-SERVICE/TRAINING LOG

DATE:	1/14/15
TOPIC:	HIPAA Compliance Training
LOCATION:	Dayton health center
TIME:	10am
PRESENTER(S):	(b)(6);(b)(7)(C)
INSERVICE/TRAINING SESSION TOPIC SUMMARY:	Review the importance of following HIPAA regulations and PPSWO HIPAA Privacy and Security policies and procedures to prevent the risk of violations.

PARTICIPANT INFORMATION

NAME	TITLE	CENTER(S) WHERE EMPLOYED	SIGNATURE
(b)(6);(b)(7)(C)	NP float	all	(b)(6);(b)(7)(C)
	APRN	Dayton	
	HCA	Dayton	
	LPN	Dayton	
	HCA	Dayton	
	HCA	Dayton	
	HCM	Dayton	
	Dir. QRM	all	
	Dir IT	all	

PLANNED PARENTHOOD SOUTHWEST OHIO REGION
IN-SERVICE/TRAINING LOG

DATE:	1/16/15
TOPIC:	HIPAA Compliance Training
LOCATION:	Call Center
TIME:	10am
PRESENTER(S):	(b)(6);(b)(7)(C)
INSERVICE/TRAINING SESSION TOPIC SUMMARY:	Review the importance of following HIPAA regulations and PPSWO HIPAA Privacy and Security policies and procedures to prevent the risk of violations.

PARTICIPANT INFORMATION

NAME	TITLE	CENTER(S) WHERE EMPLOYED	SIGNATURE
(b)(6);(b)(7)(C)	CCC	call center	(b)(6);(b)(7)(C)
	CCR	Call Center	
	CCR	Call Center	
	CCR	call center	
	CCR	call center	
	CCr	call center	
	Dir. QRM	all	
	Dir IT	all	

PLANNED PARENTHOOD SOUTHWEST OHIO REGION
IN-SERVICE/TRAINING LOG

DATE:	1/20/15
TOPIC:	HIPAA Compliance Training
LOCATION:	Springfield
TIME:	10am
PRESENTER(S):	(b)(6);(b)(7)(C)
INSERVICE/TRAINING SESSION TOPIC SUMMARY:	Review the importance of following HIPAA regulations and PPSWO HIPAA Privacy and Security policies and procedures to prevent the risk of violations.

PARTICIPANT INFORMATION

NAME	TITLE	CENTER(S) WHERE EMPLOYED	SIGNATURE
(b)(6);(b)(7)(C)	HCM	SPFlD	(b)(6);(b)(7)(C)
	APRN	Spfld	
	HCA	SF	
	LPN	Spfld	
	Dir. QRM	all	
	Dir IT	all	

PLANNED PARENTHOOD SOUTHWEST OHIO REGION
IN-SERVICE/TRAINING LOG

DATE:	1/27/15
TOPIC:	HIPAA Compliance Training
LOCATION:	Auburn Medical
TIME:	10am
PRESENTER(S):	(b)(6);(b)(7)(C)
INSERVICE/TRAINING SESSION TOPIC SUMMARY:	Review the importance of following HIPAA regulations and PPSWO HIPAA Privacy and Security policies and procedures to prevent the risk of violations.

PARTICIPANT INFORMATION

NAME	TITLE	CENTER(S) WHERE EMPLOYED	SIGNATURE
(b)(6);(b)(7)(C)	CVM	MA	(b)(6);(b)(7)(C)
	HCM	MA/Call Ctr	
	LPN	MA	
	LPN	MA	
	HCA	MA	
	CNP	MA/Floch	

PPSWO-OCR-00017

PLANNED PARENTHOOD SOUTHWEST OHIO REGION
IN-SERVICE/TRAINING LOG

DATE:	1/28/15
TOPIC:	HIPAA Compliance Training
LOCATION:	Mary Yeiser
TIME:	10am
PRESENTER(S):	(b)(6);(b)(7)(C)
INSERVICE/TRAINING SESSION TOPIC SUMMARY:	Review the importance of following HIPAA regulations and PPSWO HIPAA Privacy and Security policies and procedures to prevent the risk of violations.

PARTICIPANT INFORMATION

NAME	TITLE	CENTER(S) WHERE EMPLOYED	SIGNATURE
(b)(6);(b)(7)(C)	LPN	Yeiser	(b)(6);(b)(7)(C)
	HCA	Yeiser	
	HCA	Yeiser	
	HCM	MYC	
	LPN	MYC	
	Dir IT	all	
	Dir. QRM	all	

2015

HIPAA Compliance Training and Site Audit

Date:

Location:

Presenters: (b)(6);(b)(7)(C) HIPAA Security Officer, and (b)(6);(b)(7)(C) HIPAA Privacy Officer

Training: 60 Minutes

[illegible]	[illegible]	[illegible]
Introductions & Sign-in Sheet	(b)(6);(b)(7)(C)	2
Pre-Test		5
HIPAA Overview and Open Discussion		15
Test Your HIPAA IQ (game)		20
Open Forum – Q&A		10
Sign: *HIPAA Privacy Annual Update*		2
Post-Test and Evaluation		5

Site Audit – HIPAA Compliance:

(See attached audit tool for findings)

Page 0464 of 1306

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(b)(4)

of the Freedom of Information Act

Page 0465 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0466 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0467 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0468 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0469 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0470 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0471 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0472 of 1306

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of the Freedom of Information Act

Page 0473 of 1306

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of the Freedom of Information Act

Page 0474 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0475 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0476 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0477 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0478 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0479 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0480 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0481 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0482 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0483 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0484 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0485 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0486 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0487 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0488 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0489 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0490 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0491 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0492 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0493 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0494 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0495 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0496 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0497 of 1306

Withheld pursuant to exemption

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of the Freedom of Information Act

Page 0498 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Page 0499 of 1306

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information Act

Policy & Procedure No. 4: Record Retention Periods (45 C.F.R. 164.530(j))

There shall be a six (6) year record retention period for all documentation required or generated by these Policies & Procedures. This includes the following:

Annual Privacy Statement

- Notice of Health Information Privacy Practices
- Patient Acknowledgement Of Receipt of Notice Of Health Information Privacy Practices (see Explanation below)
- Requests For Restrictions On Use And Disclosure Of Protected Health Information
- Authorization Forms
- Requests For Access To Health Information
- Denial of Request For Access To Health Information
- Review Of Denial Of Request For Access To Health Information
- Requests For Accounting Of Disclosures Of Health Information
- Requests For Amendment Of Health Information
- Training materials and attendance sheets
- Business Associate Contracts (from date that contract ends)

Explanation:

*The Privacy Regulation specifies only the **minimum** amount of time certain documents must be retained. State retention laws may specify longer periods for certain types of records, including medical records, which must be followed.*