HIPAA PRIVACY FORMS
FOR THE
BALL STATE UNIVERSITY
EMPLOYEE BENEFIT PLAN

Adopted April 14, 2004

Revised Effective December 23, 2024

Prepared by:

The Privacy Officer of the
Ball State University Employee Benefit Plan and
Ice Miller LLP

These HIPAA Privacy Forms for the Ball State University Employee Benefit Plan ("Privacy Forms") govern the Ball State University Employee Benefit Plan ("Plan"). For purposes of these Privacy Forms, the Plan refers to any health plan or program providing medical care benefits that (i) is sponsored and administered by Ball State University ("Plan Sponsor"); (ii) is subject to the regulations found at 45 C.F.R. Parts 160, 162, and 164 ("Privacy Regulations"); and (iii) is either (A) uninsured or (B) insured and provides Protected Health Information ("PHI") to the Plan Sponsor. The Plan reserves the right to change these Privacy Forms at any time.

LIST OF HIPAA FORMS

BALL STATE UNIVERSITY EMPLOYEE BENEFIT PLAN
REQUEST TO INSPECT AND COPY HEALTH INFORMATION

You have the right to inspect and copy your protected health information, which is kept in a designated record set. This may include enrollment, payment, and claims adjudication information, but does not include: (1) psychotherapy notes; (2) information compiled in anticipation of or for use in legal actions or proceedings; or (3) protected health information that is maintained by the Plan to which access is prohibited by law.

To inspect and copy your protected health information, you must make your request in writing by filling out this form and submitting it to the Privacy Officer by mail to Employee Benefits, 2000 W University, AD G29, Muncie, IN 47306, or by email to akgregory@bsu.edu. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or preparing the requested documents.

We may deny your request to inspect and copy without an opportunity for appeal in certain very limited circumstances: (1) the protected health information you are requesting to inspect is specifically prohibited by law; or (2) the information you are requesting was confidentially obtained from a source other than a health care provider and if you were granted access, you could find out the identity of the source.

If the information you are requesting is held by one of the Plan's service providers, we will forward this request to that service provider for handling.

If information you are requesting is maintained electronically, it will be provided to you in the form and format you request if the information is readily available. If the information is not readily producible, the information will be provided to you in a readable electronic format, as agreed to by you and the Plan. You have the right to designate in this form a third party to whom the Plan can forward electronic information.

If you are denied access to your protected health information for reasons other than those listed above, you may request that the denial be reviewed. A licensed health care professional chosen by the Plan will review your request, as well as the basis for the denial. The person conducting the review will not be the person who denied your request the first time. The outcome of the review will be the final decision.

I request to inspect and copy the following records pertaining to my protected health information (please be very specific):

_____

_____

_____	_____	_____
Print Name	Social Security Number	Birth Date
_____	_____	
Signature	Date	

For further information please contact or consult the Privacy Officer, Angie Gregory, at akgregory@bsu.edu or (765) 285-2353, or see our Notice of Privacy Practices available at the same location.

FOR PLAN USE ONLY:
Date received: _____ □ Accepted □ Denied □ Forwarded to TPA
If denied, check reason for denial:
□ Excepted Information □ Confidentiality Issues
□ Other _____
Date and method of informing individual of original decision: _____
If denied, was review requested? □ Yes □ No
Name of reviewer: _____ Decision on review: _____
Date and method of informing individual of review decision: _____
Comments:_____

_____ _____
Staff Member Signature Date

BALL STATE UNIVERSITY EMPLOYEE BENEFIT PLAN
REQUEST FOR RESTRICTIONS

You have the right to request a restriction or limitation on the use or disclosure of your protected health information for purposes of treatment, payment, or health care operations. You also have the right to request that we restrict the disclosure of your protected health information from those involved in your health care or the payment for your health care, such as with a family member or friend. For example, you may request that we not use or disclose your protected health information relating to a procedure you may have had.

We are not required to agree with your request for restrictions. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing by filling out this form and submitting it to the Privacy Officer by mail to Employee Benefits, 2000 W University, AD G29, Muncie, IN 47306, or by email to akgregory@bsu.edu. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (*e.g.*, disclosures to your spouse or children).

I request the following specific restrictions to the use or disclosure or both of my protected health information:

_____

_____

_____

_____	_____	_____
Print Name	Social Security Number	Birth Date

_____	_____
Signature	Date

For further information please contact or consult the Privacy Officer, Angie Gregory, at akgregory@bsu.edu or (765) 285-2353, or see our Notice of Privacy Practices available at the same location.

FOR PLAN USE ONLY:
Date received: _____ ☐ Accepted ☐ Denied
Date and method of informing individual of decision: _____
Advised TPA of Restriction: _____
Comments:_____

_____	_____
Staff Member Signature	Date

BALL STATE UNIVERSITY EMPLOYEE BENEFIT PLAN
REQUEST FOR CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about your personal health matters in a particular way or at a particular location. For example, you can request that we only contact you at work or at a friend's house.

To request confidential communications, you must make your request in writing by filling out this form and submitting it the Privacy Officer by mail to Employee Benefits, 2000 W University, AD G29, Muncie, IN 47306, or by email to akgregory@bsu.edu. ***We require that your request contain a statement that the disclosure of all or part of the protected health information for which your are requesting a restriction could potentially harm you if disclosed.*** We will accommodate all reasonable requests. However, we may condition granting your request on receiving appropriate information regarding payment, as well as you specifying how or where you would like us to contact you.

I request the following alternative methods for communications to me by the Plan:

_____

_____

_____

By signing below, I certify that the disclosure of some or all of my protected health information in a manner other than requested could endanger me. Specify:

_____

_____

_____	_____	_____
Print Name	Social Security Number	Birth Date
_____	_____	
Signature	Date	

For further information please contact or consult the Privacy Officer, Angie Gregory, at akgregory@bsu.edu or (765) 285-2353, or see our Notice of Privacy Practices available at the same location.

FOR PLAN USE ONLY:

Date received: _____ ☐ Accepted ☐ Denied

If denied, check reason for denial:

☐ Lack of payment information

☐ Lack of an alternative address or method of contact

☐ Lack of a certification that disclosure will endanger individual

Date and method of informing individual of decision: _____

Advised TPA of Alternative Communication: _____

Comments:_____

_____

Staff Member Signature _____ Date _____

BALL STATE UNIVERSITY EMPLOYEE BENEFIT PLAN
REQUEST FOR AMENDMENT TO HEALTH INFORMATION

You have the right to request that we amend your protected health information if it is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for the Plan within a designated record set.

To request an amendment, you must make your request in writing by filling out this form and submitting it to the Privacy Officer by mail to Employee Benefits, 2000 W University, AD G29, Muncie, IN 47306, or by email to akgregory@bsu.edu. You must be prepared to provide a reason to support your request for an amendment.

We may deny your request for an amendment if the request does not include a reason to support your request for an amendment. Furthermore, we may deny your request for an amendment if you request that we amend protected health information that: (1) was not created by us, unless the person or covered entity that created the protected health information is no longer available to make the amendment; (2) is not part of the health information kept by or for the Plan within the designated record set; (3) is not part of the information which you would be permitted to inspect and copy by law; or (4) is accurate and complete.

Please explain exactly how the entry you want to amend is incorrect or incomplete. How can we make the current entry more accurate or complete? Please be very specific. Use a separate sheet of paper, if necessary.

_____

_____

If we grant your request, would you like this amendment forwarded to anyone to whom we may have disclosed your information in the past? If so, please list their names and addresses.

_____	_____
_____	_____
Name	Address

In addition to forwarding this Amendment to those whom you have listed above, we may also disclose this updated information, as necessary, to those who have the dated information and could otherwise rely upon it to your detriment.

_____	_____	_____
Print Name	Social Security Number	Birth Date

_____	_____
Signature	Date

For further information please contact or consult the Privacy Officer, Angie Gregory, at akgregory@bsu.edu or (765) 285-2353, or see our Notice of Privacy Practices available at the same location.

FOR PLAN USE ONLY:
Date received: _____ □ Accepted □ Denied
If denied, check reason for denial:
□ PHI was not created by Plan □ PHI is accurate and complete
□ PHI is not part of patient's/client's designated record set
□ PHI is not available for patient/client inspection as required by federal law (e.g. psychotherapy notes)
Date and method of informing individual of decision: _____
If denied, did individual submit a Statement of Disagreement? □ Yes □ No
If denied, did individual request a disclosure of Request and Denial with future disclosures? □ Yes □ No
Advised TPA of decision on amendment request: _____
Comments:_____

_____ _____
Staff Member Signature Date

BALL STATE UNIVERSITY EMPLOYEE BENEFIT PLAN
REQUEST FOR AN ACCOUNTING OF DISCLOSURES

You have the right to request an accounting of disclosures made by the Plan. This is a list of the disclosures we have made of your protected health information.

To request an accounting of disclosures, you must make your request in writing by filling out this form and submitting it to the Privacy Officer by mail to Employee Benefits, 2000 W University, AD G29, Muncie, IN 47306, or by email to akgregory@bsu.edu. Your request must state a time period, which may not be longer than six years, but may be shorter. The first accounting you request within a 12 month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

If your request relates to disclosures made by one of the Plan's service providers, we will forward it to the service provider to obtain an accounting of their disclosures of your protected health information.

You have a right to receive an accounting of disclosures made by the Plan, within the past six years from the date of your request, except for disclosures that have been made: (1) to carry out payment or health care operations; (2) to you; (3) incident to a use or disclosure permitted or required by law; (4) pursuant to an authorization; and (5) as part of a limited data set.

Requested Dates of Disclosures: from _____ to _____

_____	_____	_____
Print Name	Social Security Number	Birth Date

_____	_____
Signature	Date

For further information please contact or consult the Privacy Officer, Angie Gregory, at akgregory@bsu.edu or (765) 285-2353, or see our Notice of Privacy Practices available at the same location.

FOR PLAN USE ONLY:
Date received: _____
Date accounting provided: _____ Date forwarded to TPA (if applicable): _____
Comments:_____

_____	_____
Staff Member Signature	Date

BALL STATE UNIVERSITY EMPLOYEE BENEFIT PLAN
COMPLAINT FORM FOR VIOLATION OF PRIVACY RIGHTS

You may file a complaint with the Plan if you believe your privacy rights have been violated. You will not be retaliated against or penalized for filing this complaint. All complaints must be submitted in writing.

Please use the space provided below to make a complaint to the Plan. Be as specific as possible, stating dates where applicable. Use a separate sheet of paper, if necessary. We will respond to your complaint as soon as administratively feasible.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Print Name Social Security Number Birth Date

_____ _____

Signature Date

Please submit this form to the Privacy Officer by mail to Employee Benefits, 2000 W University, AD G29, Muncie, IN 47306, or by email to akgregory@bsu.edu. You may also direct any questions or obtain information from the Privacy Officer, or you may also see our Notice of Privacy Practices available at the same location.

FOR PLAN USE ONLY:

Date received: _____

Received by: _____

Comments: _____

_____

_____

_____

Action taken: _____

_____

_____

_____ _____

Staff Member Signature Date

BALL STATE UNIVERSITY EMPLOYEE BENEFIT PLAN
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____[Print Name]_____ hereby authorize the use or disclosure of my protected health information as set forth below.

Entities Authorized to Provide and Receive Information
The Ball State University Employee Benefit Plan may use my protected health information for the purpose described below or disclose my protected health information to the entity listed below for the purpose described below:

_____ is/are the person(s)/organization(s) authorized to *receive* my protected health information from the Plan.

Description of Information
Specific description of information to be used or disclosed (including date(s), type of service, claim, etc.):
_____
_____

Purpose of Use or Disclosure
Specific purpose of the disclosure ("At the request of the individual" is adequate if appropriate): _____
_____
_____

Expiration of Authorization
This authorization will expire _____ (indicate date, or an event that relates to you or to the purpose of the use or disclosure). If no expiration date or event is included, this Authorization will expire one year after its execution.

Authorization for Uses and Disclosures
The Ball State University Employee Benefit Plan may use my protected health information for the following uses and disclosures (check yes or no).
•Uses and disclosures involving psychotherapy notes:
□ Yes □ No
•Uses and disclosures for marketing purposes:
□ Yes □ No
•Uses and disclosures involving sale of protected health information:
□ Yes □ No

This authorization will expire _____ (indicate date, or an event that relates to you or to the purpose of the use or disclosure). If no expiration date or event is included, this Authorization will expire one year after its execution.

— YOUR RIGHTS —

This authorization is voluntary, and I understand that I may revoke this authorization at any time prior to its expiration date by notifying, in writing, the Privacy Officer by mail to Employee Benefits, 2000 W University, AD G29, Muncie, IN 47306, or by email to akgregory@bsu.edu, but the revocation will not have any effect on any actions taken in reliance of this Authorization or relating to the use or disclosure of the protected health information that the Plan took before it received the revocation.

I understand that I am not required to sign this authorization to become eligible or to receive my health care benefits (enrollment, treatment, or payment), unless the Plan asked me to sign this Authorization *prior* to my enrollment in the Plan and it is for the Plan's eligibility or enrollment determinations or if it is for the Plan's underwriting or risk rating determinations.

If the Plan has requested me to sign this Authorization, I understand that the Plan must provide me with a copy of this signed Authorization.

I understand that the information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

Your Signature or Your Representative's Signature

_____	_____
Signature	Date
_____	_____
Printed Name of Participant	Address
_____	_____
Printed Name of Representative (if applicable)	Relationship of Representative to Participant

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

BALL STATE UNIVERSITY EMPLOYEE BENEFIT PLAN
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

The Ball State University Employee Benefit Plan (the "Plan") recognizes that family members sometimes seek the disclosure of each other's protected health information for purposes of tracking health claims and resolving claims disputes. The Plan will not disclose protected health information to such persons unless the Plan has received an authorization from the member or spouse whose protected health information is to be disclosed.

By signing below, you are authorizing the Plan to disclose any of your protected health information held by the Plan for purposes of treatment, payment and/or operations to other family members identified below. Each Plan member or spouse must provide a signature to allow the Plan to disclose protected health information to a family member. This authorization shall remain in effect until either: (a) the applicable individual is no longer a participant in the Plan; or (b) the Plan receives a written revocation of the authorization. Limited information related to claims status and payment history may be disclosed to the member who is the primary enrollee in the Plan without this authorization, provided that the information does not include any information related to the health services or medical conditions associated with the claim.

This authorization is voluntary and only applies to protected health information related to medical care benefits offered under the Plan. I understand that I may revoke this authorization at any time prior to its expiration date by providing written notification to the Privacy Officer by mail to Employee Benefits, 2000 W University, AD G29, Muncie, IN 47306, or by email to akgregory@bsu.edu, but the revocation will not have any effect on any actions taken in reliance of this authorization or relating to the use or disclosure of the protected health information that the Plan took before it received the revocation. I understand that I am not required to sign this authorization to become eligible or to receive my health care benefits (enrollment, treatment, or payment). I understand that the information that is used or disclosed in accordance with this authorization may be redisclosed by the person who receives it and may no longer be protected by federal or state privacy laws.

Member: I, _____[Print Name]_____ hereby authorize the disclosure of my protected health information to the following family members: _____

_____.

_____ _____
Signature Date

_____
Printed Name

Spouse: I, _____[Print Name]_____ hereby authorize the disclosure of my protected health information to the following family members: _____

_____.

_____ _____
Signature Date

_____
Printed Name

BALL STATE UNIVERSITY EMPLOYEE BENEFIT PLAN
ATTESTATION FOR A REQUESTED USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION POTENTIALLY RELATED TO REPRODUCTIVE HEALTH CARE

This entire form must be completed for the attestation to be valid. Submit the completed form to the Privacy Officer by mail to Employee Benefits, 2000 W University, AD G29, Muncie, IN 47306, or by email to akgregory@bsu.edu.

Name of person(s) or specific identification of the class of persons to receive the requested protected health information (*e.g., name of investigator and/or agency making the request*):

_____

_____

Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure (*e.g., the Plan or Third Party Administrator that maintains the protected health information and/or the workforce member who handles requests for protected health information*):

_____

_____

Description of specific protected health information requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose protected health information you are requesting (*e.g., visit summary for [name of individual] on [date]; list of individuals who obtained [name of prescription medication] between [date range]*):

_____

_____

I attest that the use or disclosure of protected health information that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 C.F.R. 164.502(a)(5)(iii) because of one of the following (check one box):

☐ The purpose of the use or disclosure of protected health information is **not** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ The purpose of the use or disclosure of protected health information **is** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was **not lawful** under the circumstances in which it was provided.

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

_____ _____
Signature Date

_____
Printed Name

If you have signed as a representative of the person requesting protected health information, provide a description of your authority to act for that person.

_____

This Attestation Form may be provided in electronic format, and electronically signed by the person requesting protected health information when the electronic signature is valid under applicable Federal and state law.

LOG OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Name of Patient/Participant	*Date of Disclosure*	*Entity to Whom Disclosure Was Made*	*Disclosure Made*	*Reason for Disclosure*

DISCLOSURES LOGGED ON THIS DOCUMENT MUST BE IMMEDIATELY REPORTED TO THE PRIVACY OFFICER, ANGIE GREGORY, AT AKGREGORY@BSU.EDU OR (765) 285-2353.