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Sample

Name of Laboratory/Hospital_____ Date of Assessment_____

HIPAA Laboratory Privacy Program Self-Assessment Checklist

Item #	*Item*	*Yes*	*No*	*Documentation/Observations*
1	Is the Notice of Privacy Practices posted in the waiting room? *(Standard No 5, Notice of Privacy Practices)*			
1a	Can patients obtain a copy of the NPP at the registration desk for the lab? (Standard *No 5, Notice of Privacy Practices)*			
2	Is there a process for validating the identity and authority of the person to whom staff are releasing or sending lab results? (have staff articulate process) (*Standard No 1, Permitted uses and disclosures of PHI, and Standard No 24, Verbal disclosures of PHI to family and friends)*			
3	Do staff know the process for directly releasing lab results to patients upon receiving a HIPAA compliant requests? (have staff articulate process) (*Standard No 6 access to designated record set, and local process)*			
4	Does the laboratory leadership ensure that internal and external storage and transfer of data maintains patient confidentiality and security? CAP GEN. 41303 Patient Confidentiality; Written procedures must address patient confidentially during transfer of data to external referral laboratories or other service providers. This must include cloud based computing (e.g. for storage of confidential data), as appropriate. The laboratory must audit compliance with these procedures at least annually. Examples demonstrating compliance include:) Confirming HIV or other sensitive result access is restricted to appropriate person/s.) Fax machine preset autodial numbers are validated annually.) Physician office/reference laboratory patient data transmissions are received as originally sent.) Review access audits for staff if available. Is level of access appropriate for job responsibilities? Are PHI inquiries appropriate for job responsibilities and need to know?			
5	Do staff obtain the appropriate forms and documentation when releasing lab results to patients/attorneys, or others? (*Standard No 6, Access to designated record set)*			
6	Do staff know where to access the CHI National Privacy Polices and Standards? (ask staff to demonstrate) (*Inside CHI > About CHI > National Policies > Privacy Policies & Standards, or local posting mechanism)*			
7	Do staff have a process to check documents and papers before handing them to patients at registration and departure to ensure no improper disclosures of PHI?			
8	Is there PHI in the regular trash receptacle? (*Standard No 16 HIPAA Safeguards)*			
9	Are shred containers or other PHI disposal bins available and easily accessible by staff members? *(Standard No 16 HIPAA Safeguards)*			

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Item #	*Item*	*Yes*	*No*	*Documentation/Observations*
11	Are patient charts maintained/stored in a secure area? *(Standard No 16 HIPAA Safeguards)*			
12	Are materials removed from printers and fax machines in a timely manner? *(Standard No 16 HIPAA Safeguards)*			
13	Is the HIPAA Privacy Office approved fax coversheet available and being used? *(Standard No 16, HIPAA Safeguards)*			
14	Have all staff completed HIPAA training?			
15	Does the facility have a process and designated contact for logging applicable disclosures in the EHR system or other appropriate application? *(Standard No 8, Accounting of Disclosures of PHI)*			
16	Does the facility have a process for identifying which patients need to receive a Notice of Privacy Practices (NPP) and for collecting and documenting the patient's signed acknowledgement of receiving the NPP? (*Standard No 5 Notice of Privacy Practices)*			
17	Do staff log off computers before leaving their workstations? *(Standard No 16 HIPAA Safeguards)*			
18	Are computer monitors and printers located in secure areas, and are they positioned so that visitors can't access or view the PHI on them? *(Standard No 16 HIPAA Safeguards)*			
19	Do staff members verify fax numbers prior to use? *(Standard No 16 HIPAA Safeguards)* 9			
20	Can visitors in the waiting rooms overhear the registration process? *(Standard No 16 HIPAA Safeguards)*			
21	Are staff aware that they should only access PHI that they need to know to perform their work-related duties? *(Annual mandatory privacy education)*			
22	Do staff know that they should not access the health information of their co-workers, supervisor, family or friends? *(Annual mandatory privacy education)*			
23	Are staff aware that they can be disciplined for HIPAA law and CHI policy and standards violations, up to and including termination? *(Corrective Action for Privacy & Security violations, HR policy)*			
24	Do staff know what to do when patients request their medical records? *(Standard No 6, Access to Designated Record Set)*			
25	Do staff know what to do if patients request amendments to their medical records? *(Standard No 7 Amendment to the Designated Record Set)*			
26	Do staff know who the Privacy and Security Officers are and how to contact them? *(Inside CHI > National Groups > Privacy)*			
27	Do staff know where they should refer questions regarding patient privacy? *(Privacy Officer or HIM Manager, depending on issue)*			

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28	Does the facility have a whiteboard, patient tracker (electronic), or other posting mechanism that contains only the minimum amount of information necessary and is it located in a secure area (staff only or quasi-public area)? *(Standard No 16, HIPAA Safeguards)*			
29	Do staff use #secure# when emailing PHI beyond the CHI firewall? *(Standard No 16, HIPAA Safeguards)*			

Please review findings annually with local Privacy Officer

_____ Privacy Officer _____ Review Date

_____Signature of Laboratory Leader Completing Assessment _____ Date

Comments: