

Because some location information is needed for an effective public health response, most county health departments share some location (but not patient) information with mosquito control as need to know information for public health purposes. Some county health departments prefer to have an agreement in writing for this type of partnering. Below is a suggested template for those county health departments and mosquito control programs that wish to have a written agreement.



## **Agreed protocol for Reporting Arbovirus Human Cases to Mosquito Control Jurisdictions by County Health Departments**

### **HIPAA BUSINESS ASSOCIATE AGREEMENT**

The Florida Department of Health and its xxxxxxxx COUNTY HEALTH DEPARTMENT, hereinafter Covered Entity, and xxxxxxxxxxxx (mosquito control), hereinafter Business Associate agree to the following terms and conditions in addition to an existing agreement to perform services that involve the temporary possession of protected health information to develop a product for the use and possession of Business Associate. After completion of the contracted work all protected health information is returned to the Covered Entity or destroyed as directed by the Covered Entity.

#### **Obligations and Activities of Business Associate**

- (a) Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as required by law.
- (b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- (c) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement.
- (d) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to these same restrictions and conditions.
- (e) Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary of HHS, in a time and manner designated by the Covered Entity or the Secretary of HHS, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- (f) Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information.
- (g) Business Associate agrees to provide to Covered Entity as disclosures of protected health information occurs information collected in accordance with Section (f) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information.

#### **Obligations of Covered Entity**

Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR 164.520, as well as any changes to such notice.

#### **Permissible Requests by Covered Entity**

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

**Term and Termination**

The Term of this Agreement shall be effective upon the date of signature of the undersigned principles for the respective parties and shall terminate when Business Associate no longer possesses Protected Health Information from Covered Entity.

Xxxxxxxxxxxxxxxxxxxx (Mosquito Control)

FLORIDA DEPARTMENT OF HEALTH  
xxxxxxx County Health Department

\_\_\_\_\_  
Signature                      Date

\_\_\_\_\_  
xxxxxxxxxxxxx, Director                      Date

\_\_\_\_\_  
Print Name / Title

Approved as to Form and Legality:

\_\_\_\_\_  
xxxxxxxxxxxxx, Counsel, Fl. Dept. of Health                      Date