

SUMMARY OF THE HIPAA PRIVACY RULE

Introduction

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

1. The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used.

Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

This is a summary of key elements of the Privacy Rule and not a complete or comprehensive guide to compliance. Entities regulated by the Rule are obligated to comply with all of its applicable requirements and should not rely on this summary as a source of legal information or advice. To make it easier for entities to review the complete requirements of the Rule, provisions of the Rule referenced in this summary are cited in notes at the end of this document. To view the entire Rule, and for other additional helpful information about how it applies, see the OCR website: <http://www.hhs.gov/ocr/hipaa>. In the event of a conflict between this summary and the Rule, the Rule governs.

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Links to the OCR Guidance Document are provided throughout this paper. Provisions of the Rule referenced in this summary are cited in endnotes at the end of this document. To review the entire Rule itself, and for other additional helpful information about how it applies, see the OCR website: <http://www.hhs.gov/ocr/hipaa>.

Statutory & Regulatory Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information. Collectively these are known as the Administrative Simplification provisions.

HIPAA required the Secretary to issue privacy regulations governing individually identifiable health information, if Congress did not enact privacy legislation within OCR Privacy Rule Summary 2 Last Revised 05/03 three years of the passage of HIPAA. Because Congress did not enact privacy legislation, HHS developed a proposed rule and released it for public comment on November 3, 1999. The Department received over 52,000 public comments. The final regulation, the Privacy Rule, was published December 28, 2000.² In March 2002, the Department proposed and released for public comment modifications to the Privacy Rule. The Department received over 11,000 comments.

The final modifications were published in final form on August 14, 2002.³ A text combining the final regulation and the modifications can be found at 45 CFR Part 160 and Part 164, Subparts A and E on the OCR website: <http://www.hhs.gov/ocr/hipaa>.

Who is Covered by the Privacy Rule

The Privacy Rule, as well as all the Administrative Simplification rules, apply to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities"). For help in determining whether you are covered, use the decision tool at:

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<http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp>.

Health Plans

Individual and group plans that provide or pay the cost of medical care are covered entities.⁴ Health plans include health, dental, vision, and prescription drug insurers, health maintenance organizations (“HMOs”), Medicare, Medicaid, Medicare+Choice and Medicare supplement insurers, and long-term care insurers (excluding nursing home fixed-indemnity policies). Health plans also include employer-sponsored group health plans, government and church-sponsored health plans, and multi-employer health plans.

There are exceptions—a group health plan with less than 50 participants that is administered solely by the employer that established and maintains the plan is not a covered entity. Two types of government funded programs are not health plans:

- (1) Those whose principal purpose is not providing or paying the cost of health care, such as the food stamps program; and
 - (2) Those programs whose principal activity is directly providing health care, such as a community health center,
5. or the making of grants to fund the direct provision of health care. Certain types of insurance entities are also not health plans, including entities providing only workers’ compensation, automobile insurance, and property and casualty insurance. Health Care Providers. Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards under the HIPAA Transactions Rule.
6. Using electronic technology, such as email, does not mean a health care provider is a covered entity; the transmission must be in connection with a standard transaction. The Privacy Rule covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Health care providers include all “providers of services” (e.g., institutional providers such as hospitals) and

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“providers of medical or health services” (e.g., non-institutional providers such as physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

Health Care Clearinghouses

Health care clearinghouses are entities that process nonstandard information they receive from another entity into a standard (i.e., standard format or dLP content), or vice versa.

7. In most instances, health care clearinghouses will receive individually identifiable health information only when they are providing these processing services to a health plan or health care provider as a business associate. In such instances, only certain provisions of the Privacy Rule are applicable to the health care clearinghouse’s uses and disclosures of protected health information.⁸ Health care clearinghouses include billing services, repricing companies, community health management information systems, and value-added networks and switches if these entities perform clearinghouse functions.

Business Associates

In general, a business associate is a person or organization, other than a member of a covered entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individually identifiable health information. Business associate functions or activities on behalf of a covered entity include claims processing, dLP analysis, utilization review, and billing.

9. Business associate services to a covered entity are limited to legal, actuarial, accounting, consulting, dLP aggregation, management, administrative, accreditation, or financial services. However, persons or organizations are not considered business associates if their functions or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be incidental, if at all. A covered entity can be the business associate of another covered entity.

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Business Associate Contract

When a covered entity uses a contractor or other non-workforce member to perform "business associate" services or activities, the Rule requires that the covered entity include certain protections for the information in a business associate agreement (in certain circumstances governmental entities may use alternative means to achieve the same protections). In the business associate contract, a covered entity must impose specified written safeguards on the individually identifiable health information used or disclosed by its business associates.

10. Moreover, a covered entity may not contractually authorize its business associate to make any use or disclosure of protected health information that would violate the Rule. Covered entities that have an existing written contract or agreement with business associates prior to October 15, 2002, which is not renewed or modified prior to April 14, 2003, are permitted to continue to operate under that contract until they renew the contract or April 14, 2004, whichever is first.

11. Sample business associate contract language is available on the OCR website at: <http://www.hhs.gov/ocr/hipaa/contractprov.html>. Also see OCR "Business Associate" Guidance.

What Information is Protected

Protected Health Information. The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."12 OCR Privacy Rule Summary 4 Last Revised 05/03 "Individually identifiable health information" is information, including demographic dLP, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or

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- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.

13. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number). The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g. De-Identified Health Information. There are no restrictions on the use or disclosure of de-identified health information.

14. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either:

- 1) a formal determination by a qualified statistician; or
- 2) the removal of specified identifiers of the individual and of the individual's relatives, household agents, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

15. General Principle for Uses and Disclosures Basic Principle. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected health information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either:

- (1) as the Privacy Rule permits or requires; or
- (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.

16. Required Disclosures. A covered entity must disclose protected health information in only two situations:
(a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and
(b) to HHS when it is undertaking a compliance investigation or review or enforcement action.¹⁷ See OCR "Government Access" Guidance.

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Permitted Uses and Disclosures

Permitted Uses and Disclosures. A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations:

- (1) To the Individual (unless required for access or accounting of disclosures);
- (2) Treatment, Payment, and Health Care Operations;
- (3) Opportunity to Agree or Object;
- (4) Incident to an otherwise permitted use and disclosure;
- (5) Public Interest and Benefit Activities; and OCR Privacy Rule Summary 5 Last Revised 05/03
- (6) Limited DLP Set for the purposes of research, public health or health care operations.

18. Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make. (1) To the Individual. A covered entity may disclose protected health information to the individual who is the subject of the information. (2) Treatment, Payment, Health Care Operations. A covered entity may use and disclose protected health information for its own treatment, payment, and health care operations activities.

19. A covered entity also may disclose protected health information for the treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both covered entities have or had a relationship with the individual and the protected health information pertains to the relationship. See OCR "Treatment, Payment, Health Care Operations" Guidance.

Treatment is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.²⁰

Payment encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of

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benefits, and furnish or obtain reimbursement for health care delivered to an individual.

21. and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual. Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited dLP set, and certain fundraising for the benefit of the covered entity.

22. Most uses and disclosures of psychotherapy notes for treatment, payment, and health care operations purposes require an authorization as described below.

23. Obtaining "consent" (written permission from individuals to use and disclose their protected health information for treatment, payment, and health care operations) is optional under the Privacy Rule for all covered entities.

24. The content of a consent form, and the process for obtaining consent, are at the discretion of the covered entity electing to seek consent. OCR Privacy Rule Summary 6 Last Revised 05/03
(3) Uses and Disclosures with Opportunity to Agree or Object. Informal permission may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object. Where the individual is incapacitated, in an emergency situation, or not available, covered entities generally may make such uses and disclosures, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.

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Facility Directories

It is a common practice in many health care facilities, such as hospitals, to maintain a directory of patient contact information. A covered health care provider may rely on an individual's informal permission to list in its facility directory the individual's name, general condition, religious affiliation, and location in the provider's facility.

25. The provider may then disclose the individual's condition and location in the facility to anyone asking for the individual by name, and also may disclose religious affiliation to clergy. Agents of the clergy are not required to ask for the individual by name when inquiring about patient religious affiliation.

For Notification and Other Purposes

A covered entity also may rely on an individual's informal permission to disclose to the individual's family, relatives, or friends, or to other persons whom the individual identifies, protected health information directly relevant to that person's involvement in the individual's care or payment for care.

26. This provision, for example, allows a pharmacist to dispense filled prescriptions to a person acting on behalf of the patient. Similarly, a covered entity may rely on an individual's informal permission to use or disclose protected health information for the purpose of notifying (including identifying or locating) family agents, personal representatives, or others responsible for the individual's care of the individual's location, general condition, or death. In addition, protected health information may be disclosed for notification purposes to public or private entities authorized by law or charter to assist in disaster relief efforts.

(4) Incidental Use and Disclosure. The Privacy Rule does not require that every risk of an incidental use or disclosure of protected health information be eliminated.

A use or disclosure of this information that occurs as a result of, or as "incident to," an otherwise permitted use or disclosure is permitted as long as the covered entity has adopted reasonable safeguards as required by the Privacy Rule, and the information being shared was limited to the "minimum necessary," as required by the Privacy Rule.

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27. See OCR "Incidental Uses and Disclosures" Guidance.

(5) Public Interest and Benefit Activities. The Privacy Rule permits use and disclosure of protected health information, without an individual's authorization or permission, for 12 national priority purposes.

28. These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health information outside of the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the individual privacy interest and the public interest need for this information.

Required by Law

Covered entities may use and disclose protected health information without individual authorization as required by law (including by OCR Privacy Rule Summary 7 Last Revised 05/03 statute, regulation, or court orders).

29. Public Health Activities. Covered entities may disclose protected health information to: (1) public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect; (2) entities subject to FDA regulation regarding FDA regulated products or activities for purposes such as adverse event reporting, tracking of products, product recalls, and post marketing surveillance; (3) individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law; and (4) employers, regarding employees, when requested by employers, for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or similar state law.³⁰ See OCR "Public Health" Guidance; CDC Public Health and HIPAA

Guidance

Victims of Abuse, Neglect or Domestic Violence. In certain circumstances, covered entities may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.

31. Health Oversight Activities. Covered entities may disclose protected health information to health oversight agencies (as defined in the Rule) for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

32. Judicial and Administrative Proceedings. Covered entities may disclose protected health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

33. Law Enforcement Purposes. Covered entities may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death; (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

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Decedents

Covered entities may disclose protected health information to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.

35. Cadaveric Organ, Eye, or Tissue Donation. Covered entities may use or disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.

36. Research. "Research" is any systematic investigation designed to develop or contribute to generalizable knowledge.

37. The Privacy Rule permits a covered entity to use and disclose protected health information for research purposes, without an individual's authorization, provided the covered entity obtains either: (1) documentation that an alteration or waiver of individuals' authorization for the use or disclosure of protected health information about them for research purposes has been approved by an Institutional Review Board or Privacy Board; (2) representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that protected health information for which access is sought is necessary for the research; or (3) representations from the researcher that the use or disclosure sought is solely for research on the protected health information of decedents, that the protected health information sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is sought.

38. A covered entity also may use or disclose, without an individuals' authorization, a limited dLP set of protected health information for research purposes (see discussion below).³⁹ See OCR "Research" Guidance; NIH Protecting PHI in Research.

Covered entities may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat).

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40. Essential Government Functions. An authorization is not required to use or disclose protected health information for certain essential government functions. Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

41. OCR Privacy Rule Summary 9 Last Revised 05/03 Workers' Compensation. Covered entities may disclose protected health information as authorized by, and to comply with, workers' compensation laws and other similar programs providing benefits for work-related injuries or illnesses.

42. See OCR "Workers' Compensation" Guidance. (6) Limited DLP Set. A limited dLP set is protected health information from which certain specified direct identifiers of individuals and their relatives, household agents, and employers have been removed.⁴³ A limited dLP set may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a dLP use agreement promising specified safeguards for the protected health information within the limited dLP set.

Authorized Uses and Disclosures

A covered entity must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule.

44. A covered entity may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances.

45. An authorization must be written in specific terms. It may allow use and disclosure of protected health information by the covered entity seeking the authorization, or by a third party. Examples of disclosures that would require an individual's authorization include

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disclosures to a life insurer for coverage purposes, disclosures to an employer of the results of a pre-employment physical or lab test, or disclosures to a pharmaceutical firm for their own marketing purposes. All authorizations must be in plain language, and contain specific information regarding the information to be disclosed or used, the person(s) disclosing and receiving the information, expiration, right to revoke in writing, and other dLP. The Privacy Rule contains transition provisions applicable to authorizations and other express legal permissions obtained prior to April 14, 2003.

46. Psychotherapy Notes

47. A covered entity must obtain an individual's authorization to use or disclose psychotherapy notes with the following exceptions

48. The covered entity who originated the notes may use them for treatment.

- A covered entity may use or disclose, without an individual's authorization, the psychotherapy notes, for its own training, and to defend itself in legal proceedings brought by the individual, for HHS to investigate or determine the covered entity's compliance with the Privacy Rules, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight of the originator of the psychotherapy notes, for the lawful activities of a coroner or medical examiner or as required by law.

Marketing

Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service.

49. The Privacy Rule carves out the following health-related activities from this definition of marketing:

- Communications to describe health-related products or services, or payment OCR Privacy Rule Summary 10 Last Revised 05/03 for them, provided by or included in a benefit plan of the covered entity making the communication;

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- Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan's enrollees that add value to, but are not part of, the benefits plan;
- Communications for treatment of the individual; and
- Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or care settings to the individual. Marketing also is an arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information, in exchange for direct or indirect remuneration, for the other entity to communicate about its own products or services encouraging the use or purchase of those products or services.

A covered entity must obtain an authorization to use or disclose protected health information for marketing, except for face-to-face marketing communications between a covered entity and an individual, and for a covered entity's provision of promotional gifts of nominal value. No authorization is needed, however, to make a communication that falls within one of the exceptions to the marketing definition.

An authorization for marketing that involves the covered entity's receipt of direct or indirect remuneration from a third party must reveal that fact. See OCR "Marketing"

Guidance

Limiting Uses and Disclosures to the Minimum Necessary. A central aspect of the Privacy Rule is the principle of "minimum necessary" use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.

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50. A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

See OCR "Minimum Necessary" Guidance.

The minimum necessary requirement is not imposed in any of the following circumstances: (a) disclosure to or a request by a health care provider for treatment; (b) disclosure to an individual who is the subject of the information, or the individual's personal representative; (c) use or disclosure made pursuant to an authorization; (d) disclosure to HHS for complaint investigation, compliance review or enforcement; (e) use or disclosure that is required by law; or (f) use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules.

Access and Uses

For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of protected health information based on the specific roles of the agents of their workforce. These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the categories of protected health information to which access is needed, and any conditions under which they need the information to do their jobs.

Disclosures and Requests for Disclosures

Covered entities must establish and implement policies and procedures (which may be standard protocols) for routine, recurring disclosures, or requests for disclosures, that limits the protected health information disclosed to that which is the minimum amount reasonably necessary to achieve the purpose of the disclosure. Individual review of each disclosure is not required. For non-routine, non-recurring disclosures, or requests for disclosures that it makes, covered entities must develop criteria designed to limit disclosures to the information reasonably necessary to accomplish the purpose of the disclosure.

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Reasonable Reliance

If another covered entity makes a request for protected health information, a covered entity may rely, if reasonable under the circumstances, on the request as complying with this minimum necessary standard. Similarly, a covered entity may rely upon requests as being the minimum necessary protected health information from: (a) a public official, (b) a professional (such as an attorney or accountant) who is the covered entity's business associate, seeking

the information to provide services to or for the covered entity; or (c) a researcher who provides the documentation or representation required by the Privacy Rule for research.

Notice and Other Individual Rights

Privacy Practices Notice. Each covered entity, with certain exceptions, must provide a notice of its privacy practices.

51. The Privacy Rule requires that the notice contain certain elements. The notice must describe the ways in which the covered entity may use and disclose protected health information. The notice must state the covered entity's duties to protect privacy, provide a notice of privacy practices, and abide by the terms of the current notice. The notice must describe individuals' rights, including the right to complain to HHS and to the covered entity if they believe their privacy rights have been violated. The notice must include a point of contact for further information and for making complaints to the covered entity.

Covered entities must act in accordance with their notices. The Rule also contains specific distribution requirements for direct treatment providers, all other health care providers, and health plans. See OCR "Notice" Guidance.

Notice Distribution

A covered health care provider with a direct treatment relationship with individuals must deliver a privacy practices notice to patients starting April 14, 2003 as follows:

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- Not later than the first service encounter by personal delivery (for patient visits), by automatic and contemporaneous electronic response (for electronic service delivery), and by prompt mailing (for telephonic service delivery);
- By posting the notice at each service delivery site in a clear and prominent place where people seeking service may reasonably be expected to be able to read the notice; and
- In emergency treatment situations, the provider must furnish its notice as soon as practicable after the emergency abates.

Covered entities, whether direct treatment providers or indirect treatment providers (such as laboratories) or health plans must supply notice to anyone on request.

52. A covered entity must also make its notice electronically available on any web site it maintains for customer service or benefits information. The covered entities in an organized health care arrangement may use a joint privacy practices notice, as long as each agrees to abide by the notice content with respect to the protected health information created or received in connection with participation in the arrangement.

53. Distribution of a joint notice by any covered entity participating in the organized health care arrangement at the first point that an OHCA member has an obligation to provide notice satisfies the distribution obligation of the other participants in the organized health care arrangement.

A health plan must distribute its privacy practices notice to each of its enrollees by its Privacy Rule compliance date. Thereafter, the health plan must give its notice to each new enrollee at enrollment, and send a reminder to every enrollee at least once every three years that the notice is available upon request. A health plan satisfies its distribution obligation by furnishing the notice to the "named insured," that is, the subscriber for coverage that also applies to spouses and dependents.

- Acknowledgement of Notice Receipt. A covered health care provider with a direct treatment relationship with individuals must make a good faith effort to obtain written acknowledgement from patients of receipt of the privacy practices notice.

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54. The Privacy Rule does not prescribe any particular content for the acknowledgement. The provider must document the reason for any failure to obtain the patient's written acknowledgement. The provider is relieved of the need to request acknowledgement in an emergency treatment situation.

Access

Except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information in a covered entity's designated record set.

55. The "designated record set" is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider's medical and billing records about individuals or a health plan's enrollment, payment, claims adjudication, and case or medical management record systems.

56. The Rule excepts from the right of access the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. For information included within the right of access, covered entities may deny an individual access in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion.

Amendment

The Rule gives individuals the right to have covered entities amend their protected health information in a designated record set when that information is inaccurate or incomplete.

58. If a covered entity accepts an amendment request, it must make reasonable efforts to provide the amendment to persons that the individual has identified as needing it and to persons that the covered entity knows might rely on the information to the individual's detriment.

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59. If the request is denied, covered entities must provide the individual with a written denial and allow the individual to submit a statement of disagreement for inclusion in the record. The Rule specifies processes for requesting and responding to a request for amendment. A covered entity must amend protected health information in its designated record set upon receipt of notice to amend from another covered entity.

Administrative Policies

Background

Continuing Education requirements took effect January 1, 2011.

Individuals have three months from the date of notification of passing the exam to fulfill the continuing education requirements.

No one will be grandfathered into the program.

In order to retain their certification, all certified agents must fulfill the continuing education requirements except for those who are exempt by age or extenuating circumstance.

Age Cap

Agents 60 years of age or older in the year of their renewal do not need to fulfill the reinstatement process. However, if the member has let his/her certification lapse prior to turning 60 then reapplies upon turning 60 or older, the individual must meet the certification education requirements to be reinstated.

Extenuating Circumstances

Headquarters has the authority to extend the deadline for accruing continuing education points, upon request, for up to one year based upon extenuating circumstances such as long-term illness, undue hardship, called up for military duty, etc. Additional one-year exceptions may be granted, if required. Any points earned during such extension shall not count toward the next renewal period.

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Continuing Education Record

Each member must complete the LP Refresher Education Course and submit it to LP Headquarters by the appropriate deadline. If audited, the member must supply supporting documentation.

Notification

LP Headquarters will notify certified agents prior to the deadline for submitting their completed Refresher Education Course. Three months after their deadline, headquarters will send a notice to agents who have not submitted their paperwork, reminding them of the consequences and how to remedy the situation.

LP Employment

Employment lapses if LP paperwork is not renewed.

If a agent's certification lapses, the agent still retains his/her employment rights and benefits.

Decertification

An agent will be on hold if the appropriate paperwork has not been fulfilled by the deadline or extended deadline, as appropriate.

LP will remove any certifications from decertified agents' listings or profiles in the LP online portal.

No public lists of decertified agents will be kept. However, if asked about a particular agent, LP Headquarters will not state the member was decertified, but will state that the member is not certified.

Reinstatement

If three years or less have lapsed since the individual was an LP agent, the individual must provide the current paperwork and, if scheduled, submit his/her paperwork to be reinstated as a certified agent.

If more than three years have lapsed since the individual was an LP agent, the individual must go through Active Agent Review and then fulfill the Agent renewal requirements.

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Amendments/Revisions

Amendments and revisions to these policies can be made as approved by the LP Board of Directors.

We the agents of Language People accept as our ethical and professional duty

1. to convey meaning between people and cultures faithfully, accurately, and impartially;
2. to hold in confidence any privileged and/or confidential information entrusted to us in the course of our work;
3. to represent our qualifications, capabilities, and responsibilities honestly and to work always within them;
4. to enhance those capabilities at every opportunity through continuing education in language, subject field, and professional practice;
5. to act collegially by sharing knowledge and experience;
6. to define in advance by mutual agreement, and to abide by, the terms of all business transactions among ourselves and with others;
7. to ask for and offer due recognition of our work, and compensation commensurate with our abilities; and
8. to endeavor in good faith to resolve among ourselves any dispute that arises from our professional interactions,

Be mindful that failure to abide by these principles may harm ourselves, our fellow agents, the company, or those we serve.

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Code of Ethics and Professional Practice

This commentary is intended to be a living document, providing in-depth explanation and examples that reflect our common experiences. We envision a framework where agents will contribute examples over time of the code in practice to enable a deeper understanding of the effects of our behavior on ourselves, each other, and the industry as a whole.

We the agents of the Language People accept as our ethical and professional duty

1. to convey meaning between people and cultures faithfully, accurately, and impartially;

Linguistic integrity is at the core of what translators and interpreters do. Faithful, accurate and impartial translation or interpretation conveys the message as the author or speaker intended with the same emotional impact on the audience. Linguistic integrity is not achieved when the target language is rendered word for-word from the source language. Linguistic integrity implies that nothing is added or omitted in the target message.

- At the simplest level, a proficient translator or interpreter faced with an expression like "blind as a bat" will use an idiom that conveys the same meaning, register, and impact rather than render it word-for-word.
- Culturally specific terms, such as judicial proceedings that do not exist in the target country cannot be expanded to include a long-winded explanation of it; nor can they be omitted altogether. The translator or interpreter must come up with an appropriate term given the nature and purpose of the document or proceeding.
- Sometimes a footnote or note to the client is the best solution to an unresolvable term. Impartial translation and interpreting requires the translator or interpreter to adopt a mantle of neutrality.

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- In most cases it is not appropriate for a translator or interpreter to overlay American gender-neutral language on a language that is by nature patriarchal.
- It would also be inappropriate to “clean up” objectionable language in the target language.

2. to hold in confidence any privileged and/or confidential information entrusted to us in the course of our work;

Clients expect their information to be held in strict confidence. This includes information conveyed in a translation or during interpreting, as well as the very fact that the translation or interpreting has taken place. This holds even for published material.

It goes without saying that translators and interpreters adhere to all existing international, federal, or state laws or acts concerning confidentiality (for example, HIPAA in the medical arena). Some information is obviously sensitive and confidential, for example, information contained in personal documents, financial statements and court proceedings. But it is not always so obvious.

- Consider the case of a company needing translations of already published marketing materials to help weigh the possibility of entering a new and competitive market. If a competitor were to learn that this material is being translated, they would realize that the company is preparing to compete in that market.
- Or perhaps a prosecutor overhears interpreters cheerfully conferring about the fact that their trial has only two more defense witnesses, and they’ll be done for the day. Maybe the opposing counsel did not intend to reveal the witness lineup yet. And even if this information is already available to the public, someone overhearing these two interpreters may come away with the perception that there has been a breach of confidentiality.

It may sometimes be appropriate for an interpreter or translator to debrief or consult with a professional colleague or mentor.

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- For example, even experienced translators can use the help of colleagues to untangle the meaning of convoluted sentences or text that seems ambiguous.
 - Or an interpreter may find it helpful to debrief with a colleague or supervisor after an emotionally-charged day of interpreting.
 - Or a translator or interpreter may benefit from feedback on a particular situation. When consulting with colleagues, the translator or interpreter must give enough context to show what the problem is while limiting and disguising information so that no confidential information is disclosed.
3. to represent our qualifications, capabilities and responsibilities honestly and to work always within them;

Truth in advertising applies to professional translators and interpreters: resumes, websites, brochures, business cards and our business demeanor all need to accurately reflect who we are and what we can actually do, both practically and professionally.

- For example, a translator or interpreter resume that lists 20 or more areas of specialization and 50 Fortune 500 clients raises red flags. Make sure those lists reflect true expertise and real client relationships, not just a one-off contract through an agency for an impressive end client. Also note that if you didn't ask permission to use their name, clients may consider that listing as a breach of confidentiality.

This extends beyond listing degrees on a resume or adding a credential to an email signature: Most certifications and credentials have guidelines for how to use them; these guidelines should be strictly adhered to.

- For example, LP certification should always specify the language pair and direction of the certification. Professional translators and interpreters decline assignments that are beyond their expertise or capacity.
- For example, a translator that specializes in software may not have the expertise to produce quality legal copy.

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- Or a diplomatic conference interpreter's experience may not prepare them for interpreting in a medical setting. Subcontracting to a colleague to meet an unrealistic deadline--or for any other reason--is not acceptable without the express permission of the client.

4. To enhance those capabilities at every opportunity by continuing education in language, subject field, and professional practice;

In the face of constant change in language, technology, and business models, professional translators and interpreters travel frequently to countries to enhance their languages and cultural sensitivity, seek continuing education in subject areas, business practices and other skills. Continuing education is often a requirement for maintaining credentials.

Common strategies include:

- Attending conferences, seminars (both live and online)
- Participating in online for a
- Taking advantage of learning opportunities in a specialty areas

5. to act collegially by sharing knowledge and experience; Professional translators and interpreters share information, both informally (such as list serves) and more formally, giving workshops and mentoring. Activities include:

- Participating in online for a and social media communities,
- Volunteering (both for professional societies and humanitarian causes),
- Authoring articles and books,
- Presenting at conferences and seminars
- Mentoring

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Everyone benefits from this sharing: learning by teaching, enjoying increased exposure and improved perception of their expertise and abilities. In addition to the valuable information that is shared, the association and industry benefit from the professionalism that is reflected by those sharing. Collegial behavior also includes refraining from negative statements about colleagues.

- For example, if a translator is contracted to edit a colleague's work, the translator should limit critique to substantiated, objective comments about the project at hand.

6. to define in advance by mutual agreement, and to abide by, the terms of all business transactions among ourselves and with others; It is widely considered best practice to use a contract or other agreement tool to avoid misunderstandings. The responsibility for this is shared by both parties to an agreement.

There is a range of instruments available, from a simple email or telephone conversation all the way to a formal contract that undergoes full legal review. Whatever the instrument, the agreement must be fair and acceptable to both parties.

- For example, an interpreter may get a call to interpret immediately for a patient in an emergency room. During the conversation, a rate is agreed upon, and the interpreter sends a quick SMS to the client to confirm. This meets the need for immediacy and provides the interpreter with basic protection in case of a misunderstanding about fees.

- Or a translator may receive a 10-page contract from a translation company with several clauses, including one stipulating the client's right to inspect the translator's premises. Since this might breach confidentiality for the translator's other clients, the translator strikes through the clause in question and signs the contract.

There is no single standard contract for the translation and interpretation industry. Contracts often contain language relating to non-competition, independent contractor status, intellectual property transfer, cancellation/nonperformance, and other best practices. Even if these issues are not specifically addressed in an agreement, best business practices and fairness still apply.

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- For example, it is inappropriate for an independent contractor to solicit or accept business directly from a contact made through a translation company even if no non-competition clause has been signed. Independent translators and interpreters often have templates ready to use with clients who do not have their own contracts or agreements for translators or interpreters to sign.

7. to ask for and offer due recognition of our work, and compensation commensurate with our abilities; Due recognition means that translators may seek acknowledgement for their work. For example:

- Literary translators often negotiate to have their name (and bio) included on the title page, flap and/or and cover of a book.
- Translators of corporate financial reports may request to have their names included in the mastheads.
- Software localizers' names commonly appear in the list of people who worked on the program.
- Seattle baseball fans are used to seeing their favorite Japanese players accompanied by interpreters: the Seattle Mariners make sure the interpreter's name gets mentioned in the press.

All language service providers are free to negotiate fees that realistically reflect their experience, skills, and quality of service.

8. To endeavor in good faith to resolve among ourselves any dispute that arises from our professional interactions; LP has no authority over the business matters (see the Policy of Non- Involvement in Commercial Disputes, 2002) of its agents. LP agents (both corporate and individual) who find themselves in disagreement with each other are encouraged to resolve their differences as they would resolve any other business dispute.

- Example: A translation company is contesting the quality of a translation they received. Possible solutions: 1) translator acknowledges that translation is not up to standard and agrees to rework the translation; 2) translator and company agree to bring in a third party to evaluate and/or edit the document at shared cost.

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- Example: The due date for an invoice has come and gone, and the client is unresponsive to calls and emails. The translator, after following best business practices to encourage payment can resort to standard resources commonly used by small businesses such as collection agencies, reporting to payment lists or even small claims court.

Complaints about illegal behavior on the part of another LP member may be brought to the LP Ethics Committee. A document outlining the procedure is posted on the LP website and available from LP headquarters. This document describes the organization of the LP Ethics Committee, and gives the steps for filing and reviewing complaints, determining if a violation has taken place, outlining a process for deciding and appealing sanctions in accordance with LP bylaws.

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