

May 6, 2021

Robinsue Frohboese
Acting Director and Principal Deputy
Office for Civil Rights
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, SW
Washington, DC 20201

Submitted Electronically

Attention: Proposed Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care NPRM, RIN-0945-AA00.

Dear Acting Director Frohboese:

On behalf of the 162,000 members of the American Dental Association (ADA), we are writing to you in regards to the Notice of Proposed Rulemaking (NPRM) on modifications to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. As an organization dedicated to supporting dentists and advancing the oral health of the public, we welcome the opportunity to share our thoughts on how changes to the HIPAA Privacy Rule could impact dentistry.

Consideration of provider burden.

The ADA urges OCR, when developing the final rule, to consider the burdens regulatory changes will impose on covered providers, particularly smaller covered providers. Some of the proposed changes could inconvenience patients, take time away from patient care, disrupt schedules, or overburden dental offices. Examples include the proposed 15-day timeframe for responding to requests for access, the proposal to permit patients to access, copy, and photograph their protected health information (PHI) at the time of their appointments, and the proposed requirement that covered providers develop fee schedules for providing copies of PHI and post such schedules on their websites if they maintain websites. Some covered dental practices may need to hire additional staff to support such activities; since HIPAA compliance activities are unreimbursed, the cost would be borne by the dental practice and could lead to higher costs for patients. While some proposed changes, such as the proposed removal of the Notice of Privacy Practices (NPP) acknowledgment requirement, may save covered entities limited staff time to the extent the underlying process is not automated, that time savings is dwarfed by the time and expense that would be imposed on covered entities for understanding, developing, and implementing other proposed changes to the Privacy Rule.

Request for delayed enforcement.

The ADA urges CMS to provide ample time, no less than 365 days, in advance of any enforcement date to permit covered providers to make appropriate revisions, implement

changes, and train workforce members. If finalized, many of the changes proposed in the notice of proposed rulemaking will require covered dental practices to undertake time consuming activities, such as revising their Notices of Privacy Practices and their HIPAA Privacy policies and procedures, implementation of new workflows, and training. The proposed effective date (60 days after publication of the final rule) and compliance date (180 days after the effective date) are unlikely to provide covered entities, particularly small businesses, sufficient time to come into compliance with the extensive changes proposed in the notice of proposed rulemaking. Many covered entities rely on outside individuals and entities, including the ADA and its endorsed vendors as well as law firms and consultants, to inform, advise, and support their HIPAA compliance due to the law's complexity; thus, it may best serve compliance if these covered entities wait until these individuals and entities analyze rule changes, update their information, resources, and products, and provide support to the covered entities as appropriate. Bringing such covered entities into compliance with changes to the Privacy Rule in 60 days would be onerous, particularly in these difficult times.

Access options and fees.

A number of the proposed rule changes pertain to individuals' options for inspecting, receiving, or transmitting their PHI. As a whole, these proposed changes are confusing, complex, and seem overly complicated for responding to a simple record request. Attempting to navigate this complicated mix of regulatory options and obligations will result in burdens for patients and for covered entities, particularly covered entities that are small businesses.

Responding to questions about options and the process for and consequences of each option will be time consuming and burdensome for patients and for covered entities, particularly small businesses. The time and money that would be required to revise dental practice policies and procedures, train staff, and administer the proposed changes in compliance with HIPAA would be better spent on providing and improving patient care in the dental operatory and service in the dental practice business office. Further restricting covered entities' right to charge fees for copies of PHI could increase a covered entity's cost to engage a business associate to administer the provision of copies of PHI on behalf of the covered entity, and could narrow covered entities' options for engaging such business associates if the latter are unable to operate under the reduced fee structure.

The extensive proposed changes would be overly burdensome for covered providers at any time, but particularly now when patients and dentists are still dealing with the COVID-19 public health emergency. Even when the public health emergency is no longer in effect, patients and dentists will face a backlog of delayed care for a period of time. Patient care should be the priority. The ADA urges OCR to make no changes to the HIPAA Privacy Rule access provisions until such time as large and small dental practices will not struggle to find the time and staff resources to understand the changes and develop and implement modifications to the dental practice's HIPAA policies and procedures.

Definitions of electronic health record and personal health application.

The ADA urges OCR to define "health-related information on an individual" in the proposed definition of "electronic health record (EHR)" to exclude a limited data set of protected health information. If a covered entity or its business associate uses a limited data set of PHI for research, public health, or health care operations, the electronic record of such limited data

set should not be considered an electronic health record for purposes of the Privacy Rule even if the limited data set may be “consulted” by a clinician or staff member (the proposed definition does not limit consultation to treatment purposes) and even if there might be a reasonable basis to believe information in the limited data set could be used to identify the individual.

Modifying provisions on the individual right of access to PHI:

- **Providing individuals a right to inspect their PHI in person, which includes allowing individuals to take notes or use other personal resources to view and capture images of their PHI.**

The ADA urges OCR not to finalize the proposed change, and asks OCR to continue to require covered entities to arrange with the individual for a convenient time and place to inspect their PHI. Allowing individuals, at the time of their dental appointments, to immediately inspect their PHI, take notes, photographs, and videos, make audio recordings, and use other means of capturing copies of their PHI, would be overly burdensome for dental practices. It would also interrupt workflows, be disruptive to other patients, and could increase the risk of a breach of unsecured PHI.

On occasion, dental office staff would likely need to delay their responsibilities to other patients in order to spend time assisting individuals who wish to exercise this right. The dental office staff member would need to simultaneously facilitate the access, protect the integrity of the data, and guard against access to PHI of other patients. Staff time spent this way instead of at assigned responsibilities could at best inconvenience other patients and at worst risk compromising patient care.

Photography, video, and audio recording in the dental office risks capturing the images and voices of other patients. Dental practices may have determined in their HIPAA Security Risk Analysis that these recordings pose an unreasonable risk to the confidentiality, integrity, and availability of electronic PHI (ePHI) and therefore may have prohibited them as risk management.

Even a large dental practice is unlikely to have sufficient small, enclosed rooms where patients with appointments on any given day might exercise this proposed right without advance notice. This is true even if OCR elects to finalize the proposal along with protections such as requiring patients to provide advance notice of a request to immediately review PHI and setting a time limit on the maximum amount of time that a patient may spend inspecting and copying records. The proposal could still lengthen appointment times without advance warning, throw off other patients' treatment schedules, compromise patient safety (for example, if patient arrives unexpectedly with a dental emergency and staff is tied up helping another patient videotape their records), and require health care providers to spend time on administrative matters that should be spent on patient care.

The proposed change providing that a covered entity is not required to allow an individual to connect a personal device to the covered entity's information system is a benefit to both patients and covered providers, as it would help protect the confidentiality, integrity, and availability of PHI. The ADA urges OCR to finalize this proposed change as a standalone provision.

The ADA asks OCR not to expressly prohibit a covered entity from imposing unreasonable measures that would impede an individual's right of access. Such a requirement would lack the clarity that covered entities require for consistent compliance.

- **15 calendar day response time for responding to requests for access.**

The ADA urges OCR not to finalize the proposal to require covered entities to respond to requests for access to PHI as soon as practicable but not later than 15 days, with a possibility of one 15-day extension provided the covered entity has a policy to address urgent or high-priority requests. The ADA urges OCR to retain the current 30-day response period with a possibility of one 30-day extension.

The proposed requirement to have a policy to address urgent or high-priority requests in order to have the possibility of a 15-day extension may be an incentive to covered entities to develop and implement such policies, but it is not clear why the possibility of a 15-day extension should be conditioned on having such a policy in place. OCR does not propose to define what constitutes an urgent or high priority request, so there will likely be no uniformity across covered entities, which could result in inconsistency and patient confusion. The ADA urges OCR to make the possibility of an extension available to all covered entities in the interest of fairness, whether or not they have such policies in place.

A 15-day time frame would burden covered providers, particularly small providers that may not be staffed to accelerate workflows to achieve compliance in half the time currently allotted.

Moreover, small dental practices may close for a period of time so the staff can participate in charitable dental care activities such as a Give Kids a Smile or M.O.M (Mission of Mercy) event, or to permit staff to attend continuing education programs. A dental office may close for holidays and vacations: a five-day office closure over the Fourth of July weekend would shorten the response time from 15 days to ten. If a dental office is short-staffed due to a staff member's illness, a 15-day response time may be unachievable. Even if a temp fills in, it may not be possible to train the temp in the dental office's HIPAA-compliant processes for providing access to PHI in time to properly fulfill requests within the 15-day response period. If an unexpected event occurs, such as a power outage, storm, or ransomware attack, compliance with the 15-day limitation may be impossible.

The proposed 15-day time frame for response would apply to PHI in any format, including electronic, paper and other hard copies, radiographs, etc. If PHI such as paper records, radiographs, or models are stored offsite, retrieving requested PHI could result in delays. Delays may also be caused by unclear patient requests: for example, a patient may not recall the name of the treatment location or the name of the treating dentist, particularly at a large dental practice, or if more than one dentist has the same name, as in the case of a common name or a dental office where more than one family member practices. The practice may require clarification regarding a patient's name change if the PHI is under more than one name; for example, a patient who changes their name upon marriage, or a transgender patient. If a request is unclear or the dental practice requires additional information to locate the PHI, the dental practice may need to contact the patient or risk a breach of unsecured PHI by providing the wrong patient's PHI. Seeking clarification from the patient can result in further delays, particularly if the patient is unable to promptly respond to requests for clarification or additional information.

ADA also urges OCR not to deem “practicable” a requested form and format for electronic protected health information if another applicable federal or state law requires a covered entity to provide access in the shorter period of time. This proposed requirement will cause confusion in light of HIPAA preemption rules to the extent not already required as “more stringent” law, and could further stress covered entities rushing to meet a 15-day deadline, with possible inconvenience and even treatment interruption or delay to patients as a result.

- **Clarifying the form and format required for responding to individuals’ requests for their PHI.**

The ADA urges OCR not to deem ePHI transmitted via a personal health app a “readily producible” form and format unless the form and format is, in fact, readily producible from the perspective of the particular covered entity. This change should also apply only to covered entities who must comply with the Information Blocking Rule and who have certified EHR technology that meets all the necessary security standards.

We ask that OCR not permit third parties to use personal health apps to circumvent other options for transmitting ePHI, as not all dental offices and patients use such apps.

The ADA also urges OCR not to impose any obligation on covered entities to educate patients about the risks of providing other entities or parties access to their PHI. Covered providers cannot be expected to keep up to date on the evolving risks in this fast-changing environment, nor to train staff to advise patients concerning such risks.

- **Requiring covered entities to inform individuals that they retain their right to obtain or direct copies of PHI to a third party when a summary of PHI is offered in lieu of a copy.**

The ADA urges OCR not to require covered entities to inform a patient, when offering a summary in lieu of access to PHI, that the individual retains the right to obtain a copy of the requested PHI (or direct an electronic copy of PHI in an EHR to a third party) if they do not agree to receive the summary. Such a provision would unnecessarily complicate dental office procedures and risk confusing patients.

- **Reducing the identity verification burden on individuals exercising their access rights.**

The ADA asks OCR not to impose restrictions on requests for identity verification, and to continue to leave the type and manner of the verification to the discretion and professional judgment of the covered entity. Identity verification is an important patient protection that helps guard against financial identity theft, medical identity theft, and other harms, such as reputational harm, that might result to a patient from a breach of unsecured PHI. Identity verification can also help protect covered entities from the cost, stress, and other potential harms that can result from a breach of unsecured PHI.

The proposed change is complicated and confusing. It is not clear which identity verification methods would be permissible in which situations. Identity verification helps protect PHI from unauthorized access, particularly in difficult cases such as requests from individuals who are not known to the dental practice, noncustodial parents, executors and family members of deceased patients, unrelated caregivers, and identity thieves.

Fraud and fraudulent identification is an age-old problem, intensified in this era of electronic communications and deep fake technology. ADA urges OCR to permit covered entities to impose identity verification methods that the covered entity deems necessary to protect individuals and the covered entity.

- **Creating a pathway for individuals to direct the sharing of PHI in an electronic health record among covered health care providers and health plans, by requiring covered health care providers and health plans to submit an individual's access request to another health care provider and to receive back the requested electronic copies of the individual's PHI in an electronic health record, and requiring covered health care providers and health plans to respond to certain record requests received from other covered health care providers and health plans when directed by individuals pursuant to the right of access.**

While the ADA supports facilitating PHI exchanges among covered entities at the direction of the individual, the ADA is concerned that the proposed change will provide an opportunity for fraud. If a dental practice receives a request for PHI from an unfamiliar entity, which may not even be in the dental practice's geographic location, the proposed change may require the dental practice to respond in a very short time frame with limited ability to verify the legitimacy of the request and the identity of the Requester-Recipient. The Requester-Recipient may not even be whom they claim to be, but instead an identity thief or ransomware attacker. This puts patients at risk of identity theft and puts Discloser covered entities at risk of a data breach and, in the event of a ransomware attack, can harm patients generally by compromising the availability, and potentially the confidentiality and integrity, of their PHI.

The ADA urges OCR to not finalize this provision. If the provision were to be finalized, ADA urges OCR to:

- Require that the individual be a patient of record of the Discloser;
- Permit the Discloser to deny requests from a Requester-Recipient when the Discloser determines in its professional judgment that fulfilling the request is not in the best interest of the individual (for example, if the Discloser believes in good faith that the Requester-Recipient or the request is not legitimate; there should be a presumption of good faith in the case of such denials, which should not be subject to review);
- Provide both the Discloser and the Requester-Recipient 30 rather than 15 days to act on such a request, for reasons discussed above;
- Specify that the time frame for response begins to run when the Discloser and Requester-Recipient have all the information and clarification necessary to fulfill the response, including but not limited to any verification of the validity of the request and the identity of the Requester-Recipient that the covered entity deems reasonable and appropriate to protect the confidentiality, integrity, and availability of its ePHI (in order to prevent data breaches due to wrongdoers posing as Requester-Recipients in order to fraudulently obtain PHI);
- Provide a possibility of a 30-day extension;
- Specify that neither the Discloser nor the Requester-Recipient is required to determine whether the other is covered by HIPAA; and

- Permit the Requester-Recipient to deny requests from individuals to obtain PHI from another covered entity when the Requester-Recipient does not need, or already has, the PHI.

The ADA urges OCR not to hold Disclosers and Requester-Recipients responsible for any failure to determine, or attempt to determine, whether the other is in fact covered by HIPAA.

The ADA asks OCR to permit Disclosers to charge a reasonable, cost-based fee for providing such records.

- **Limiting the individual right of access to direct the transmission of PHI to a third party to electronic copies of PHI in an electronic health record.**

The ADA supports OCR's proposal to require a covered entity to respond to an individual's request to direct an electronic copy of PHI in an electronic health record to a third party designated by the individual when the request is clear, conspicuous, and specific (which may be orally or in writing), rather than the current rule which requires such requests to be in writing, signed by the individual, and clearly identify the designated third party and where to send the copy of the PHI. However, the ADA urges OCR to permit covered entities the option to require such requests, or any particular request, be submitted in writing as the covered entity deems appropriate. This would help protect the patient from the risk that the covered entity may inadvertently send PHI to the wrong recipient due to a miscommunication.

- **Specifying when electronic PHI must be provided to the individual at no charge.**

The ADA urges OCR to permit covered entities to charge a reasonable, cost-based fee for any category of access, including on-site inspection and copying with the individual's own device, as well as for individuals who use an internet-based method to view and capture or obtain an electronic copy of PHI maintained by or on behalf of the covered entity, as well as for electronic copies provided on media such as a USB drive. The covered entity should be permitted to charge a reasonable, cost based fee for the media, if provided by the covered entity, as well as for the cost of postage or shipping (for example, if the patient requests hard copies or that the storage media be sent via overnight courier). Even on-site inspection may be cumbersome and time-consuming for staff (as discussed above), and a reasonable fee could help prevent unreasonable or abusive inspection requests.

The ADA also does not believe that OCR is correct to anticipate that there would be no associated costs incurred by the covered entity when an individual uses an internet-based method to direct an electronic copy of PHI in an EHR to any third party, when an individual uses such a method to direct a covered health care provider or health plan to submit an access request to another covered health care provider, or when an individual submits a request through a health care provider or health plan to other providers and plans using such a method. This may be the case for large health systems, but small dental practices do not have these systems and there will be costs associated with upgrading and compliance.

- **Amending the permissible fee structure for responding to requests to direct records to a third party.**

The ADA urges OCR not to limit covered entities to charging a reasonable cost-based fee, as proposed, when the individual directs an electronic copy of PHI in an electronic health record to a third party. This fee structure could make it difficult for covered entities to provide requested PHI in a timely manner, particularly if the time frame for response is shortened to 15 days. The fee structure could also make it difficult for covered entities to engage business associates to respond to such requests on behalf of covered entities. Large dental practices with massive patient records may require assistance in responding to such requests, and small dental practices may not have the staff to respond to such requests, particularly if they need to store PHI offsite. The burden to covered entities of not being adequately compensated for providing a copy of PHI when a third party is involved dwarfs any benefit to the patient from the proposed change, particularly in cases where the third party and not the patient underwrites the cost.

- **Requiring covered entities to post estimated fee schedules on their website, if they maintain websites, for access and disclosures with an individual's valid authorization and, upon request, provide individualized estimates of fees for an individual's request for copies of PHI, and itemized bills for completed requests.**

The ADA urges OCR not to require covered entities: (1) To post estimated fee schedules on their websites; (2) To provide, upon request, electronic and hard copy individualized estimates of fees for an individual's request for copies of PHI; or (3) To provide itemized bills for completed requests. It would be difficult for covered providers, particularly small businesses, to comply with this requirement and develop a fee schedule taking into account all possible variables. Small providers may lack sufficient staff to develop and maintain the fee schedule and to provide individualized estimates and itemized bills. It is also unclear how such a requirement would allow for a meaningful decision by the individual regarding the scope of a contemplated request, or the form and format requested. Before the request is made the individual will not have, and the covered entity may not be able to provide, information such as the form and format in which the covered entity maintains the PHI (e.g., electronic, hard copy, or legacy electronic format), the size and scope of the contemplated request (e.g., page count for hard copy records), and the provision under which the individual will exercise their right to obtain or direct copies.

Amending the definition of health care operations to clarify the scope of permitted uses and disclosures for individual-level care coordination and case management that constitute health care operations.

The ADA supports OCR's proposal, which could support care coordination and case management by facilitating the use and disclosure of PHI for this purpose, and could help clarify that PHI may be used and disclosed for both individual-level and population-based care coordination and case management.

Creating an exception to the "minimum necessary" standard for individual-level care coordination and case management uses and disclosures.

The ADA supports OCR's proposal to create the proposed exception to the minimum necessary standard, which could relieve covered dental practices of the burden of determining the minimum necessary PHI when sharing PHI with a health plan or covered health care provider for care coordination and case management at the individual level.

ADA urges OCR to clarify that covered dental practices may rely on the scope of a request for PHI for such purposes if reasonable.

Clarifying the scope of covered entities' abilities to disclose PHI to social services agencies, community-based organizations, home and community based service (HCBS) providers, and other similar third parties that provide health-related services, to facilitate coordination of care and case management for individuals.

The ADA supports OCR's proposal to provide that covered entities may disclose PHI without the individual's valid authorization to such organizations providing health-related social services or other supportive services, whether or not the organization is providing treatment and even if the organization is not a health care provider, to facilitate coordination of care and case management for individuals. ADA urges OCR to specify that a covered entity may make such disclosures based on the covered entity's good faith belief that the disclosure is in the best interest of the individual, and that there is a presumption that the covered entity making such a disclosure is acting in good faith.

Replacing the privacy standard that permits covered entities to make certain uses and disclosures of PHI based on their "professional judgment" with a standard permitting such uses or disclosures based on a covered entity's good faith belief that the use or disclosure is in the best interests of the individual.

The ADA supports OCR's proposal to permit covered entities to use or disclose PHI without the individual's authorization based on the covered entity's good faith belief that the disclosure is in the best interest of the individual, and agrees that there should be a presumption that the covered entity doing so is acting in good faith.

The ADA also supports OCR's proposal to permit covered entities to disclose PHI when the individual is present if the covered entity reasonably infers from the circumstances, based on a good faith belief, that the individual does not object to the disclosure, rather than based on the exercise of professional judgment as in the current rule.

The ADA further supports OCR's proposal to change "professional judgment" to "good faith belief" and "reasonable inferences" in the provision permitting covered entities to make limited uses and disclosures of PHI when the individual is not present, which will help covered providers better support patients by making appropriate disclosures of PHI, for example, when the dentist detects signs a substance use disorder or eating disorder and believes in good faith that it is in the patient's best interest to make a disclosure. The proposed changes could help promote family involvement in the care of patients experiencing such a health condition.

The ADA further supports the OCR proposal to amend the Privacy Rule to permit a covered entity to disclose the PHI of an unemancipated minor to a parent or guardian who is not the personal representative of the individual under HIPAA if it is consistent with state or other applicable law and if a licensed health care professional has a good faith belief that disclosing the PHI is in the best interests of the individual.

Expanding the ability of covered entities to disclose PHI to avert a threat to health or safety when a harm is "serious and reasonably foreseeable," instead of the current stricter standard which requires a "serious and imminent threat" to health or safety.

The ADA supports OCR's proposal to permit covered entities to disclose PHI to avert a "serious and reasonable foreseeable" threat to health or safety, rather than the current stricter standard which requires the threat be "imminent." This change would help covered dental practices assist patients by disclosing PHI to individuals who may be able to offer support to the patient, for example, when a patient is in danger, without having to determine whether the threatened harm is "imminent." ADA urges OCR to clarify that this disclosure is permitted whether or not the patient has the right or the opportunity to object to the disclosure. The ADA also supports OCR's proposal to provide that a covered entity acting on such a belief meets the identity verification requirement when acting in good faith, and that good faith is presumed.

Eliminating the requirement to obtain an individual's written acknowledgment of receipt of a direct treatment provider's Notice of Privacy Practices.

The ADA supports OCR's proposal to eliminate the requirement to obtain an individual's written acknowledgment of receipt of a direct treatment provider's NPP (and, if unable to obtain the written acknowledgment, to document their good faith effort to obtain the acknowledgment and the reason for not obtaining the acknowledgment), and to eliminate the requirement to retain copies of such documents for six years. The current requirement to obtain acknowledgement is confusing, time consuming, and burdensome for patients, who are often asked to sign the acknowledgement at a time when they are completing multiple documents such as health history, insurance, and other forms, and can confuse patients who may believe that they are being asked to agree to the terms of the NPP. The current requirement is also time consuming and burdensome for dental practices.

Modifying the content requirements of the Notice of Privacy Practices to clarify for individuals their rights with respect to their PHI and how to exercise those rights.

The ADA urges OCR not to require covered providers to provide an electronic notice of privacy practices "automatically and contemporaneously in response to the individual's first request for service" in cases where the first service delivery to the individual is delivered electronically. Smaller providers may not have the capability of automatic, contemporaneous electronic delivery of the notice at the time of a first request for service, particularly if the request comes via telephone (for example, a new dental patient requesting an appointment via videoconference).

The ADA supports OCR's proposal to make optional an NPP provision concerning directing PHI to a third party. Many covered entities may find it challenging to draft such a provision, particularly in light of the many proposed options, fees, and so forth, and may wish to work with patients directly to provide information and respond to questions concerning this process.

Expressly permitting disclosures to Telecommunications Relay Services (TRS) communications assistants for persons who are deaf, hard of hearing, or deaf-blind, or who have a speech disability, and modifying the definition of business associate to exclude TRS providers.

The ADA urges OCR to make the proposed changes, which would expressly permit not only patients but also workforce members of covered entities and business associates that need a TRS, to use TRS to communicate PHI without the need for the individual's authorization or agreement or a business associate agreement with the TRS.

Cost-Benefit analysis.

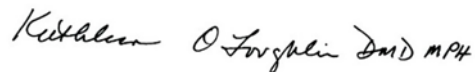
ADA disagrees with OCR's assessment that the cost of compliance would not fall disproportionately on small entities. While the change might result in some cost savings over time, the compliance burden (such as revising policies and procedures, retraining staff, revising the Notice of Privacy Practices, developing and posting fee schedules, and complying with burdensome and time consuming requests to inspect and record PHI at appointment time) will fall disproportionately on small entities, which lack the in-house legal, administrative, and technical personnel and expertise of large covered entities. Small covered entities, such as solo and small group dental practices, are more likely to lack in-house capabilities to manage the changes, and are more likely to need to hire consultants to assist with the changes and staff to manage them. This burden dwarfs the average estimated cost per covered entity of \$150 in year one, followed by an average estimated savings of \$1,065 thereafter, cited in the notice of proposed rulemaking.

Thank you again for the opportunity to comment on the HIPAA Privacy Rule NPRM. The ADA looks forward to continuing to work with OCR. Should you have any questions, please do not hesitate to contact Ms. Roxanne Yaghoubi at yaghoubir@ada.org.

Sincerely,



Daniel J. Klemmedson, D.D.S., M.D.
President



Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

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