## Purpose

The purpose of this Policy is to set forth [COVERED ENTITY]’s process for the use and disclosure of Protected Health Information (“PHI”) pursuant to a written authorization.

## Policy

In accordance with the HIPAA Privacy Rule, when PHI is to be used or disclosed for purposes other than treatment, payment, or health care operations, [COVERED ENTITY] will use and disclose it only pursuant to a valid, written authorization, unless such use or disclosure is otherwise permitted or required by law. Use or disclosure pursuant to an authorization will be consistent with the terms of such authorization.

## Procedure

1. Exceptions to Authorization Requirements. PHI may be disclosed without an authorization if the disclosure is:
   1. Requested by the patient or his personal representative (authorization is never required);
   2. For the purpose of treatment;
   3. For the purpose of [COVERED ENTITY]’s payment activities, or the payment activities of the entity receiving the PHI;
   4. For the purpose of [COVERED ENTITY]’s health care operations;
   5. In limited circumstances, for the health care operations of another Covered Entity, if the other Covered Entity has or had a relationship with the patient;
   6. To the Secretary of the U.S. Department of Health and Human Services for the purpose of determining compliance with the HIPAA Privacy Rule; or
   7. Required by other state or federal law. (See “Request and Disclosure Table” in the “Uses and Disclosures of Protected Health Information” Policy for other exceptions.)
2. Use or Disclosure Pursuant to an Authorization.
   1. PHI may never be used or disclosed in the absence of a valid written authorization if the use or disclosure is:
      1. Of psychotherapy notes as defined by the HIPAA Privacy Rule, except if the disclosure is to carry out the following treatment, payment, or health care operations:
         1. use is by the originator of the psychotherapy notes for treatment;
         2. use or disclosure by [COVERED ENTITY] for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or
         3. use or disclosure by [COVERED ENTITY] to defend itself in a legal action or other proceeding brought by the individual;
      2. For the purpose of marketing, except if the communication is in the form of a face-to-face communication made by [COVERED ENTITY] to an individual; or a promotional gift of nominal value provided by [COVERED ENTITY]; and
      3. The sale of PHI.
   2. If the use or disclosure requires a written authorization, [COVERED ENTITY] shall not use or disclose the PHI unless the request for disclosure is accompanied by a valid authorization.
   3. If the request for disclosure is not accompanied by a valid written authorization, [COVERED ENTITY] shall notify the requestor that it is unable to provide the PHI requested.
   4. If the request for disclosure is accompanied by a written authorization, [COVERED ENTITY] will review the authorization to ensure that it is valid.
      1. If the authorization is lacking a required element or does not otherwise satisfy the HIPAA requirements, [COVERED ENTITY] will notify the requestor, in writing, of the deficiencies in the authorization. No PHI will be disclosed unless and until a valid authorization is received.
      2. If the authorization is valid, [COVERED ENTITY] will disclose the requested PHI to the requester. Only the PHI specified in the authorization will be disclosed.
   5. Each authorization shall be filed in the patient’s Medical Record.
3. Preparing an Authorization for Use or Disclosure.
   1. When [COVERED ENTITY] is using or disclosing PHI and an authorization is required for the use or disclosure, [COVERED ENTITY] will not use or disclose the PHI without a valid written authorization from the patient or the patient’s personal representative.
   2. The authorizationmust contain all required elements of a valid HIPAA authorization and must be signed and dated by the patient or the patient’s personal representative before the PHI is used or disclosed.
   3. [COVERED ENTITY] may not condition the provision of treatment on the receipt of an authorization unless it is providing research-related treatment or health care that is solely for the purpose of creating PHI for disclosure to a third party (i.e., performing an independent medical examination at the request of an insurer or other third party).
   4. An authorization may not be combined with any other document unless one of the following exceptions applies:
      1. Authorizations to use or disclose PHI for a research study may be combined with any other type of written permission for the same research study, including a consent to participate in such research;
      2. Authorizations to use or disclose psychotherapy notes may only be combined with another authorization related to psychotherapy notes; or
      3. Authorizations to use or disclose PHI other than psychotherapy notes may be combined, but only if [COVERED ENTITY] has not conditioned the provision of treatment or payment upon obtaining the authorization.
4. Revocation of Authorization. A patient may revoke his or her authorization at any time. The authorization may ONLY be revoked in writing. Upon receipt of a written revocation, [COVERED ENTITY] may no longer use or disclose a patient’s PHI pursuant to the authorization. Each revocation will be filed in the patient’s Medical Record.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Authorization**. I authorize the use or disclosure by [COVERED ENTITY] of my health information as described below. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

2. **Protected Health Information to be Disclosed**. The type and amount of information to be used or disclosed is as follows (check the appropriate item(s), and include other information where indicated):

* Problem list
* Immunization record
* Laboratory results from \_\_\_\_\_\_\_\_ (date) to \_\_\_\_\_\_\_\_ (date)
* X-ray and/or imaging reports from \_\_\_\_\_\_\_\_ (date) to \_\_\_\_\_\_\_\_ (date)
* Consultation reports from (please provide doctors’ names) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medication list
* Most recent history and physical
* List of allergies
* Most recent discharge summary
* Entire record
* Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. Please check if your authorization will include the disclosure of the following types of protected health information:

* **Substance abuse** (including alcoholism)
* **AIDS, AIDS-related complex, or HIV**
* **Mental health services** (excluding psychotherapy notes)

3. **Authorized** **recipient of the protected health information**. This information may be disclosed to, and used by, the following individuals or organizations.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. **Purpose of the Disclosure.** This information is being disclosed for the following purpose(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. **Expiration and Revocation**. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to [COVERED ENTITY]. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. **For Marketing disclosures only: *(Check if applicable)*** \_\_\_\_\_\_I understand that [COVERED ENTITY] will receive compensation related to the use or disclosure of the requested information.

7. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative’s Title (e.g., Guardian, Executor of Estate,

Health Care Power of Attorney

**PATIENT AUTHORIZATION TO DISCLOSE PHI:**

**A CHECKLIST OF ELEMENTS REQUIRED BY THE HIPAA PRIVACY RULE**

A covered entity may disclose information pursuant to an authorization **only if** the authorization form includes **all** of the following elements required by the Privacy Rule. **If any one element is missing, the Privacy Rule prohibits disclosure.**

**Note**: Authorizations for research purposes must include additional elements.

* A specific and meaningful description of the information to be disclosed.
* The name or other specific identification of the person (or organization or class of persons) authorized to make the requested disclosure.
* The name or other specific identification of the person (or organization or class of persons) to whom the information will be disclosed.
* The purpose(s) of the requested disclosure. (If the patient initiates the authorization, the statement “at the request of the patient” is a sufficient description of the purpose).
* Signature of the patient or personal representative and date.
* If signed by personal representative, a description of the representative’s authority to act for the patient.
* A statement informing the patient of his or her right to revoke the authorization in writing and a statement explaining (1) how to revoke the authorization, and (2) any exceptions to the right to revoke **or** a the revocation right and procedures described in the Notice of Privacy Practices.
* A statement that the covered entity cannot condition treatment, payment, or eligibility for benefits on the patient’s agreeing to sign the authorization
* A statement that information disclosed pursuant to the authorization may be re-disclosed by the recipient and no longer protected by the federal privacy regulations
* A statement that the authorization will expire: (1) on a specific date, (2) after a specific amount of time (e.g., 5 years), **or** (3) upon the occurrence of some event related to the patient or the purpose of the authorization

**If the authorization is for marketing purposes and the covered entity will receive direct or indirect remuneration from a third party**, the authorization **must** include, in addition to all of the elements listed above:

* A statement that the covered entity will receive direct or indirect remuneration in connection with the use or disclosure of the patient’s information for marketing.