

SUNY DOWNSTATE MEDICAL CENTER

UNIVERSITY HOSPITAL OF BROOKLYN
POLICY AND PROCEDURE

No. HIPAA-13

Subject: USES AND DISCLOSURES FOR
MARKETING ACTIVITIES

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I. PURPOSE

To ensure all marketing communications involving the use of protected health information (PHI) are authorized by the patient, when necessary, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

II. POLICY

All marketing activities will be reviewed by the Office of Policy and Planning to determine whether patient authorization is required. No marketing activity may be conducted without first undergoing this review process.

III. DEFINITIONS

Face to Face Communications- Conversations between a provider and a patient/ personal representative that occur when the two are physically located in the same space. Conversations made over the phone, mail or e-mail do not constitute face to face communications.

Financial Remuneration- Direct or indirect payment from or on behalf of a third party whose product or service is being described. Direct payment means financial remuneration that flows from the third party whose product or service is being described directly to Downstate. Indirect payment means financial remuneration that flows from an entity on behalf of the third party whose product or service is being described to Downstate. Non- financial benefits, such as in- kind benefits, provided to Downstate in exchange for making a communication about a product or service are not included in the “financial” remuneration definition.

Marketing- To make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. Marketing **does not include** a communication made:

1. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the patient, only if any financial remuneration received by Downstate in exchange for making the communication is reasonably related to Downstate’s cost of making the communication. This exception includes communications:

- a. Made regarding the generic equivalent of a drug being prescribed to an individual;
- b. Encouraging individuals to take their medications as directed; and
- c. Regarding all aspects of a drug delivery system for self- administered drugs or biologics, such as insulin pumps.

2. For the following treatment and health care operation purposes, **except where Downstate receives financial remuneration from a third party in exchange for making the communication:**

- a. For the treatment of the patient by the provider, including case management or care coordination for the patient, or to direct or recommend alternative treatments, therapies, health care providers or settings of care to the patient (Ex: Mailing a letter recommending ointments for patients with a skin rash, recommending exercise programs or massage services to pregnant patients);
- b. To describe a health-related product or service (or payment for such product or service) that is provided by SUNY Downstate or covered by the patient’s insurance (Ex: Using a patient list to announce the arrival of a new specialty group or the acquisition of new equipment through a general mailing or publication); including communications about:
 - i. The entities participating in Downstate’s network;
 - ii. Replacement of, or enhancements to, a health plan; and
 - iii. Health related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits.
- c. For case management or care coordination, contacting of patients with information about treatment alternatives and related functions to the extent these activities do not fall within the definition of treatment.

3. Promoting health in general and that do not promote a product or service from a particular provider, such as communications promoting a healthy diet, annual

mammogram mailings, support groups, organ donation, cancer prevention and health fairs.

4. About government and government- sponsored programs as there is no commercial component to communications about benefits through public programs. (Ex: Eligibility for Medicare/ Medicaid)

IV. RESPONSIBILITIES

It is the responsibility of all medical staff members and hospital staff members to comply with this policy. Medical staff members include physicians as well as allied health professionals. Hospital staff members include all employees, medical or other students, trainees, residents, interns, volunteers, consultants, contractors and subcontractors at the hospital.

V. PROCEDURE/GUIDELINES

A. Marketing Activities Not Requiring Patient Authorization- A patient's written authorization is not required for the use and disclosure of protected health information for the following marketing communications made directly to patients:

1. Face to Face communications made by a Downstate provider to a patient, including:
 - a. Infant products provided to new mothers as they leave the maternity ward;
 - b. Leaving general circulation materials for patients to pick up during office visits.
2. Communications involving a promotional gift of nominal value. Examples include giving pens, calendars and toothbrushes to patients.

C. Marketing Activities Requiring Patient Authorization- Other than communications excluded under section V.A. above, any marketing communication, including related to treatment and/or health care operations, where Downstate or its business associate receives direct or indirect financial remuneration specifically for making the communication from the third party whose product or service is being marketed requires patient authorization. The financial remuneration Downstate receives from a third party must be for the purpose of making the communication and such communication must encourage patients to purchase or use the third party's product or service. If the financial remuneration received by Downstate is for any purpose other than for making the communication, this marketing authorization requirement does not apply.

1. The attached Authorization for Marketing Communications form must be utilized to obtain written authorization from the patient.
 - a. The authorization must disclose the fact that Downstate is receiving financial remuneration from a third party.
 - b. The scope of the authorization need not be limited only to subsidized communications related to a single product/ service or the products/ services of one third party, but rather may apply more broadly to subsidized communications

generally so long as the authorization adequately describes the intended purposes of the requested uses and disclosures.

- c. The authorization must make it clear to the patient that s/he may revoke the authorization at any time s/he wishes to stop receiving marketing material.
- 2. Business Associates- An authorization is required even if an outside vendor or business associate receives financial remuneration from a third party in exchange for making a marketing communication about a product or service on behalf of SUNY Downstate or on its own behalf.
- 3. Patients that have revoked a marketing authorization will be maintained by the Office of Institutional Advancement and may not be sent further marketing communications, unless a new marketing authorization has been obtained.

D. Accounting of Disclosures- All disclosures of protected health information made for marketing activities must be documented in accordance with the policy on Accounting of Disclosures.

VI. ATTACHMENTS

Authorization for Marketing Communications

VII. REFERENCES

Standards for Privacy of Individually Identifiable Health Information, 45 CFR §164.501, §164.508(a)

Date	Revision	Required	Responsible Staff Name and Title
01/2017	Yes	(No)	Shoshana Milstein /AVP, Compliance & Audit
	Yes	No	
	Yes	No	
	Yes	No	



AUTHORIZATION FOR MARKETING COMMUNICATIONS

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to communicate with you about the products and services described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. A representative of SUNY Downstate Medical Center is available to answer any questions regarding this authorization.

Patient Name: _____ MR#: _____

Address: _____

DOB: _____ Telephone#: _____(Day) _____(Eve)

1. Persons/ Organizations providing the information:

- University Hospital of Brooklyn- Main; specify department _____
- University Hospital of Brooklyn- Lefferts
- University Hospital of Brooklyn- Midwood
- University Hospital of Brooklyn- Dialysis Center
- University Physicians of Brooklyn, Inc. (UPB); specify practice name _____
- Research Foundation
- Student/ Employee Health
- Other; specify _____

2. The information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

Telephone #: _____

3. Information to be disclosed:

4. New York State regulations [NY Public Health Law §2782(1)(b)] require a special authorization for release of information regarding mental health, any HIV- related condition (including HIV-related test, illness, AIDS or any information indicating potential exposure to HIV) or drug and alcohol abuse.

- Do not authorize release of this information.
- Authorize release of this information; specify the information to be released: _____

5. This information is being used or disclosed in order to provide information about the following products or services:

6. Will SUNY Downstate Medical Center receive direct or indirect remuneration for communicating with you or assisting others to communicate with you about these products or services?

___ Yes ___ No

I understand that this authorization will expire 6 months from the date this form is signed, unless otherwise stated below:

Expiration Date/ Event: _____

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from re-disclosing any HIV-related information without your authorization, unless permitted to do so under federal or state law. If you experience discrimination because of the release of disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

You have a right to refuse to sign this authorization. Your healthcare, the payment for your healthcare and your healthcare benefits will not be affected if you do not sign this form.

You have a right to receive a copy of this form after you sign it.

You have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon your authorization. To revoke this authorization, please write to:

*SUNY Downstate Medical Center
Office of Institutional Advancement
450 Clarkson Ave.
Brooklyn, NY 11203*

By signing below, I acknowledge that I have read and accept all of the above.

Print Name of Patient

Signature of Patient

Date

If you are signing as a personal representative of the patient, read and sign below:

I, _____, hereby certify and attest that I am the duly authorized personal representative of _____ and that I have the lawful provisions set forth in this authorization and agree to the use and/or disclosure of the patient's information for the purposes set forth herein.

Print Name

Signature

Date

A COPY OF THIS SIGNED AUTHORIZATION FORM MUST BE PROVIDED TO THE PATIENT OR PERSONAL REPRESENTATIVE.