SUNY DOWNSTATE MEDICAL CENTER
UNIVERSITY HOSPITAL OF BROOKLYN
POLICY AND PROCEDURE

Subject: **USES AND DISCLOSUIRES REQUIRING PATIENT AUTHORIZATION**

Prepared by: Shoshana Milstein, RHIA, CHP, CCS

Reviewed by: Renee Poncet

Approved by: Margaret Jackson, MA, RN

William P. Walsh, MBA, MSW

Patricia Winston, MS, RN

Michael Lucchesi, MD

No. HIPAA-32

Original Issue Date 11/2002

Supersedes: 09/2013

Effective Date: 12/2016

TJC Standards: RI.01.01.01: The hospital respects, protects, and promotes patient rights.
LD.04.02.03: Ethical principles guide the hospital's business practices.

Issued by: Regulatory Affairs

I. PURPOSE

To establish a policy and procedure to ensure that patient authorization for release of protected health information (PHI) is obtained, when necessary, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

II. POLICY

It is the policy of UHB not to use or disclose PHI for purposes other than treatment, payment or healthcare operations (TPO) without a valid authorization consistent with the use or disclosure, unless such use or disclosure is otherwise permitted or required under the Privacy Rule or other state or federal laws.

III. DEFINITION(s)

None

IV. RESPONSIBILITY

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. Core Elements- A valid authorization must contain at least the following elements:

1. The name of the person or class of persons authorized to make the use or disclosure of PHI.
2. Identification of the physician, individual, third party designee or agency to whom the covered entity is authorized to make the requested use or disclosure (including name and address).
3. Description of the information to be used or disclosed- Including dates of service, inpatient/ outpatient record and type of document (.Ex: history and physical, discharge summary, etc.).
4. Description of each purpose of the requested use or disclosure- The statement "at the request of the individual" is sufficient when an individual initiates the authorization and does not provide a statement of the purpose.
5. An expiration date or expiration event that relates to the individual or to the purpose or use of the requested disclosure- The statement "at the end of the research study" is sufficient if the authorization is for a use or disclosure for research, including for the creation and maintenance of a research database or research repository.
6. A statement of the patient's right to revoke the authorization in writing (subject to certain limitations) and a description of how the patient may revoke the authorization.
7. A statement as to whether treatment, payment, enrollment or eligibility for benefits is conditioned upon the signing of the authorization.
8. A statement that the information used or disclosed under the authorization may be subject to re-disclosure by the recipient and no longer be protected under the Privacy Rule.
9. The signature of the patient or personal representative and the date of the signature.
10. A description or copy of legal paperwork of the personal representative's authority to sign the authorization, if applicable.

B. Conditioning Authorizations- SUNY Downstate may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on the provision of an authorization, except:

1. For the provision of research related treatment; or
2. For the purpose of creating PHI for disclosure to a third party.

C. Compound Authorizations- An authorization for use or disclosure of PHI cannot be combined with any other document to create a compound authorization, except as follows:

1. An authorization for the use or disclosure of PHI for a research study may be combined with any other type of written permission for the same research study, including consent to participate in such research. This includes combining an authorization for the use or disclosure of PHI for a research study with another authorization for the same research study, with an authorization for the creation or maintenance of a research database or repository, or with a consent to participate in research.

a. The compound authorization must clearly differentiate between the conditioned and unconditioned components and provide the individual with an opportunity to opt in to the research activities described in the unconditioned authorization. The opt in methodology should utilize a check box for the unconditioned research activity and should require a distinct signature line to signal that the individual is authorizing optional research that will not affect research related treatment.

2. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes.

3. An authorization, other than for (1) and (2) above, may be combined with any other authorization except when a covered entity has conditioned the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on the provision of one of the authorizations.

D. Revocation of Authorization- SUNY Downstate will allow a patient to revoke an authorization, in writing, at any time except to the extent that action has already been taken in reliance of it. Revocation of a compound authorization must clearly specify whether the revocation applies to both of the components or one of the components.

E. Defective Authorizations- An authorization to use or disclose PHI is not valid if the document submitted has any of the following defects:

1. The expiration date has passed or the expiration event is known by SUNY Downstate to have occurred;
2. The authorization has not been filled out completely with respect to the required core elements (See Section III.A.);The authorization is known by SUNY Downstate to have been revoked in writing;
3. The authorization violates the Privacy Rule in terms of conditioning authorizations or compound authorizations (See Section III.B. & C.);
4. Any information in the authorization is known by SUNY Downstate to be false.

F. Other Requirements

1. The authorization must be written in plain language.
2. If the use or disclosure involves PHI related to mental health, HIV or alcohol and drug abuse, the authorization should explicitly reference that such information will be released pursuant to the authorization.
3. All signed authorizations must be documented and retained.
4. A copy of the signed authorization must be given to the patient.

PROCEDURE

A. Obtaining Authorization- A staff member should be available to assist the patient with any questions regarding the authorization.

1. For use or disclosure of PHI for purposes other than TPO, the patient should be given an authorization, written in plain language, which is specific to the requested use or disclosure.
2. All core elements of the authorization must be completely filled out.
3. The authorization cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits, except as provided in Section III.B & C.

4. The authorization cannot be combined with any other document, except as provided in Section III.C.
5. The patient or the patient's personal representative must sign and date the authorization.
6. If the patient's personal representative signed the authorization, a description of the personal representative's authority should be documented.
7. If upon receipt, it is determined that the authorization is defective, the authorization should be returned to the requestor with an explanation as to why it cannot be honored.
8. The signed authorization should be filed in the patient's medical record.
9. A copy of the signed authorization should be given to the patient.

B. Revocation

1. If a patient wishes to revoke an authorization, s/he should be directed to write to the Department of Health Information Management (HIM), Correspondence Unit, Box #119, including the following information:
    a. Patient Name;
    b. DOB;
    c. Specific use or disclosure revoking; including specification of the particular component being revoked from a compound authorization, if applicable; and
    d. Date of revocation.
2. Upon receipt of the request, the Department of HIM will notify the appropriate personnel to no longer use or disclose the PHI as delineated in the authorization.
3. The letter of revocation should be filed in the medical record, adjacent to the original authorization.

VI. ATTACHMENTS

Authorization Form

VII. REFERENCES

Standards for Privacy of Individually Identifiable Health Information- 45 CFR Parts 160 and 164; 164.501, 164.508, 164.532

Date Reviewed	Revision Required (Circle One)		Responsible Staff Name and Title
9/2013	(Yes)	No	Shoshana Milstein, AVP, Compliance & Audit
9/2016	Yes	(No)	Shoshana Milstein, AVP, Compliance & Audit
12/2016	Yes	(No)	Shoshana Milstein, AVP, Compliance & Audit

SUNY Downstate Medical Center

HIPAA AUTHORIZATION FORM

Person/organization disclosing the information:		
Patient Last Name, First Name:	Maiden or Other Name:	Patient Date of Birth:
Patient Address:		
City, State & Zip:	Telephone: (Area Code and Number)	Medical Record Number:

By initialing here _____, I authorize SUNY Downstate Medical Center to discuss my health information with the following individual.

Name, address and telephone number of person or entity to whom this information will be sent:

- ☐ Check here if same as above.
- ☐ Check here if the person or entity is another healthcare provider.

Name: _____
Address: _____
Phone #: _____

Specific information to be released:

- ☐ Medical record from (insert date) _____ to (insert date) _____.
- ☐ Entire Medical Record, including patient histories, office notices (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other _____

New York State regulations (NY Public Health Law S 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 you want the following types of records included: *(indicate by checking the line and initialing)*

- ☐ Alcohol and Drug Treatment _____
- ☐ Mental Health Information _____
- ☐ HIV-Related Information _____

This information is being used or disclosed for the following purposes:	☐ Patient Request ☐ Treatment ☐ Insurance/ Payment ☐ Legal ☐ Other: _____

HIPAA AUTHORIZATION FORM- PAGE 2

What type of access are you requesting?

- ☐ Schedule physical inspection of records
- ☐ Obtain summary of records
- ☐ Obtain explanation of records
- ☐ Obtain copy of the records (paper or electronic)- specify format below:
  - ○ Pick up
  - ○ Send by mail
  - ○ CD
  - ○ Regular email*
  - ○ Encrypted email
  - ○ Electronic portal
  - ○ USB Drive

If requesting records to be emailed, please specify email address: _____

**Regular, un-encrypted email is not secure and could result in your medical records being intercepted, read and copied during transmission or while being stored in your inbox. By signing this notice, you are acknowledging that you're aware of and accepting the risk by requesting your medical records to be sent via regular email.*

Fees: Photocopies: $0.39/page for first 200 pages; $0.12/page for pages 201-400; Free for >400 pages.
Electronic media/ Email: Flat fee of $6.50
Mammograms: Flat fee of $6.50
Summaries/ Explanations: Dependent upon number of hours and physician hourly consult rate.

- 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 and 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 the 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
  Health Information Management Department
  450 Clarkson Avenue, MSC #119
  Brooklyn, NY 11203

I understand that this authorization will expire in 6 months from the date this form is signed, unless otherwise stated below: Expiration Date/Event: _____

By signing below, I certify that I am requesting access to my health information in the manner described above and I will be contacted about fees prior to the execution of my request for medical records.

Print Name of Patient/Personal Representative	Signature of Patient/Personal Representative
Description of Personal Representative's Authority	Date