

SUNY DOWNSTATE MEDICAL CENTER

UNIVERSITY HOSPITAL OF BROOKLYN
POLICY AND PROCEDURE

No. HIPAA-35

Subject: SALE OF PROTECTED HEALTH INFORMATION (PHI)

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I. PURPOSE

To ensure any sale of protected health information (PHI) occurs only pursuant to a valid, written authorization from the patient who is the subject of the information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

II. POLICY

SUNY Downstate and any of its business associates will not disclose PHI in exchange for direct or indirect financial or non- financial remuneration unless a valid, written authorization for the sale of PHI has been obtained from the relevant patient(s). All sale of PHI activities must first be reviewed and approved by the Office of Institutional Advancement.

III. DEFINITIONS

Financial Remuneration- Direct or indirect payment from or on behalf of a third party. Direct payment means financial remuneration that flows from the third party directly to SUNY Downstate. Indirect payment means financial remuneration that flows from an entity on behalf of the third party to SUNY Downstate.

Non- Financial Remuneration- Non- financial benefits, such as in- kind benefits, provided to SUNY Downstate in exchange for the PHI.

Sale of PHI- A disclosure of PHI by SUNY Downstate or its business associate where SUNY Downstate (or its business associate) receives direct or indirect financial or non- financial remuneration from or on behalf of the recipient of the PHI in exchange for the PHI.

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. Authorization Requirements- An authorization must be obtained for the disclosure of PHI in exchange for direct or indirect financial or non- financial remuneration constituting a sale of PHI under the Privacy Rule.

1. The attached Authorization for the Sale of Protected Health Information must be obtained for every patient whose information is disclosed for a sale of PHI, as that term is defined by HIPAA.
2. The authorization must state that the disclosure will result in remuneration to SUNY Downstate.

B. Sale of PHI Exclusions- There are several exceptions to the authorization requirement for circumstances where the purpose of the exchange is for:

1. Public health activities;
2. Research purposes, where the only remuneration received by SUNY Downstate or its business associate is a reasonable cost-based fee to cover the cost to prepare and transmit the PHI for such purposes. This may include both direct and indirect costs, including labor, materials and supplies for generating, storing, retrieving and transmitting the PHI; labor and supplies to ensure the PHI is disclosed in a permissible manner; as well as related capital and overhead costs. Fees charged to incur a profit from the disclosure of PHI are not allowed.
3. Treatment and payment purposes;
4. The sale, transfer, merger, or consolidation of all or part of SUNY Downstate and for related due diligence as described in the definition of health care operations;
5. A disclosure of PHI to or by a business associate for activities that the business associate undertakes on behalf of SUNY Downstate, or on behalf of a business associate in the case of a subcontractor and the only remuneration provided is by

SUNY Downstate to the business associate, or by the business associate to the subcontractor, for the performance of such activities;

6. A disclosure of PHI to an individual, when requested under an individual's right to access personal records or when requesting an accounting of disclosures;
7. A disclosure required by law as permitted under the Privacy Rule; and
8. A disclosure for any other purpose permitted by and in accordance with the applicable requirements of the Privacy Rule, where the only remuneration received by SUNY Downstate or its business associate is a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by other law.

C. Disclosure of PHI as a Byproduct of a Service- A sale of PHI does not encompass payments SUNY Downstate may receive in the form of grants or contracts or other arrangements to perform programs or activities, such as a research study, because any provision of PHI is a byproduct of the service being provided. In addition, the exchange of PHI through a health information exchange (HIE) that is paid for through fees assessed on HIE participants is not a sale of PHI; rather the remuneration is for the services provided by the HIE and not for the data itself.

D. Access to Downstate PHI Database- Before SUNY Downstate or its business associate may allow a third party access to a database containing PHI in exchange for remuneration, an authorization must be obtained from the patient unless an exception under Section V.B. applies to the disclosure.

E. Transition Provisions for Limited Data Sets- The use or disclosure of a limited data set in accordance with an existing data use agreement (DUA), including for research purposes, is permitted until the DUA is renewed or modified or until September 23, 2014, whichever is sooner, even if such disclosure would otherwise constitute a sale of PHI.

VI. ATTACHMENTS

Authorization for the Sale of Protected Health Information

VII. REFERENCES

Standards for Privacy of Individually Identifiable Health Information, 45 CFR §164.502(a)(5), §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 SALE OF PROTECTED HEALTH INFORMATION (PHI)

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 disclose your protected health information for the purpose 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 for the following purpose:

Please note that SUNY Downstate Medical Center will be receiving direct or indirect financial or non- financial (such as in- kind benefits) remuneration in exchange for the disclosure of this information.

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.