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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Prepared by: Shoshana Milstein

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Reviewed by: Ron Najman

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Approved by: Anny Yeung, RN, MPA

The JC Standards:

Margaret Jackson, MA, RN

David Conley, MBA

Stanley Fisher, M.D.

Michael Lucchesi, M.D.

Debra D. Carey, MS

Ivan M. Lisnitzer

Issued by: Regulatory Affairs

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 to determine whether patient authorization is required. No marketing activity may be conducted without first undergoing this review process.

III. DEFINITION

A. Marketing Definition

1. Marketing activities include all oral and written communications with a patient about a product or service that encourages the patient to purchase or use that product or service. This includes:

a. Using or disclosing patient information for direct marketing at current or former patients (Ex: Sending patient brochures endorsing another organization's products not necessary for the specific patient's treatment);
b. Distributing patient information to another organization so that it may market its own products and services if direct or indirect remuneration is being received (Ex: Selling patient lists to a pharmaceutical manufacturer for its own drug promotions).

2. Marketing does not include communications made:
    a. To describe a health-related product or service that is provided by SUNY Downstate or indicating whether it is 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);
        i. Disease management or wellness programs operated by SUNY Downstate or its business associate would not be considered marketing (Ex: Sending a flyer about a new weight loss program to all patients meeting the definition of obesity);
        ii. Population based activities in the areas of health education or disease prevention promote health in a general manner instead of promoting a specific product or service and would therefore not be considered marketing (Ex: Annual mammogram mailings, support groups, organ donation, cancer prevention and health fairs).
    b. For treatment of the patient (Ex: Prescription refill reminders, referrals to specialists); and
    c. For case management, care coordination for the patient or to direct or recommend alternative treatments, therapies, healthcare 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, Social Services sharing information with nursing homes in recommending the patient's transfer to a nursing home).

B. 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 that patients:

1. Communications that occur face to face. Examples include:
    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 values, whether or not they are health related. Examples include giving pens, calendars and toothbrushes to patients.

C. Marketing Activities Requiring Patient Authorization- For all other types of marketing communications, protected health information may only be used or disclosed with the patient's written authorization. See attached Authorization for Marketing Communications form.

1. Requirements of an authorization form- See the policy on Uses & Disclosures Requiring Patient Authorization for specific requirements of an authorization form. Some of the requirements include;
    a. Stating a specific expiration date for the authorization;
    b. Stating any confidential HIV-related information that will be disclosed; and
    c. Not conditioning the patient's treatment, payment, enrollment or eligibility for benefits upon the provision of the authorization.

2. Business Associates- An authorization is required even if an outside vendor or business associate is making the marketing communication on behalf of SUNY Downstate or on its own behalf.

3. If the marketing involves direct or indirect remuneration to SUNY Downstate from a third party, the authorization must state that remuneration is involved. The specific type or amount of remuneration does not have to be disclosed.

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.

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

The development of the procedure section is the responsibility of the respective department. It is dependent upon the unique needs of each department's operating structure and shall be advanced and customized accordingly.

VI. ATTACHMENTS

Authorization for Marketing Communications

VII. REFERENCES

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

	Revision	Required	Responsible Staff Name and Title
	Yes	No	Adeola O. Dabiri, Director of Regulatory Affairs
	Yes	No	
	Yes	No	
	Yes	No	

SUNY DOWNSTATE Medical Center

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- Throop
   __ 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.