

# UNIVERSITY PHYSICIANS OF BROOKLYN, INC.

## POLICY AND PROCEDURE

No: \_\_\_\_\_

**Subject:** USES & DISCLOSURES REQUIRING  
PATIENT AUTHORIZATION

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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. Definitions:

**Protected Health Information (PHI)-** Individually identifiable health information transmitted or maintained in any form or medium, including demographic information collected from an individual, that:

- A. Is created or received by a healthcare provider, health plan or healthcare clearinghouse; and
- B. Relates to the past, present or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to the individual; and
  - 1. That identifies the individual; or
  - 2. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

**Use-** The sharing, employment, application, utilization, examination or analysis of individually identifiable information **within** an entity.

**Disclosure-** The release, transfer, provision of access to, or divulging in any other manner of information **outside** the entity.

III. **Policy:** It is the policy of UPB 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.

**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 person 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 and type of document (Ex: history and physical, test results, 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.
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-** UPB may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on the provision of an authorization, except for the purpose of creating PHI for disclosure to a third party.

**C. Compound Authorizations-** An authorization 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-** UPB 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.

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 The authorization is known by UPB to have been revoked in writing;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

**F. Prior Authorizations-** UPB may use or disclose PHI pursuant to an authorization or other express legal permission obtained from the patient prior to the compliance date of April 14, 2003, provided that:

1. The use or disclosure is valid only for PHI that was created or received by SUNY Downstate prior to the compliance date;
2. The authorization or express legal permission specifically permits such use or disclosure;

- and
3. There is no agreed-to restriction on the use or disclosure.

#### **G. 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.

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

#### **V. 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, that 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.
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 specific practice including the following information:
  - a. Patient Name
  - b. DOB
  - c. Specific use or disclosure revoking
  - d. Date of revocation
2. Upon receipt of the request, the Practice must 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. Reasons for Revision:** Institutional/regulatory changes

**VII. Attachments:** Authorization Form

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



# UNIVERSITY PHYSICIANS BROOKLYN, INC.

## **AUTHORIZATION FORM**

*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 for the purposes 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 University Physicians of Brooklyn, Inc. is available to answer any questions regarding this authorization.*

Patient Name: \_\_\_\_\_ MR#: \_\_\_\_\_

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

DOB: \_\_\_\_\_ Telephone#: \_\_\_\_\_ (Day) \_\_\_\_\_ (Eve)

1. Persons/ Organizations disclosing the information: \_\_\_\_\_

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

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

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

Telephone #: \_\_\_\_\_

3. Information to be disclosed:

\_\_\_ A. Complete Outpatient Medical Record

\_\_\_ B. Partial Outpatient Medical Record:

Period(s) of treatment from: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_ History & Physical Examination

\_\_\_ Progress Notes

\_\_\_ Consultation Reports

\_\_\_ Test Results; specify \_\_\_\_\_

\_\_\_ Other; specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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:

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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:*

*University Physicians of Brooklyn, Inc.*  
\_\_\_\_\_ Practice

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