SUNY DOWNSTATE MEDICAL CENTER

UNIVERSITY HOSPITAL OF BROOKLYN
POLICY AND PROCEDURE

No. HIPAA-32

Subject: **USES AND DISCLOSUIRES 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. 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 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, 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.

2. An authorization, other than for (1) 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.

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. Prior Authorizations- SUNY Downstate may use or disclose PHI, for purposes other than research, 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.

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 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
    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

	Revision	Required	Responsible Staff Name and Title
	Yes	**No**	**Adeola O. Dabiri**
	Yes	**No**	
	Yes	**No**	
	Yes	**No**	

SUNY DOWNSTATE Medical Center

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 SUNY Downstate Medical Center is available to answer any questions regarding this authorization.

Patient Name: _____MR#: _____

Address: _____

_____

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

1. Persons/ Organizations disclosing the information:
   __ University Hospital of Brooklyn- Main
   __ University Hospital of Brooklyn- Lefferts
   __ University Hospital of Brooklyn- Midwood
   __ University Hospital of Brooklyn- Throop
   __ University Hospital of Brooklyn- Dialysis Center
   __ SUNY Downstate Medical Center at Bay Ridge
   __ University Physicians of Brooklyn, Inc. (UPB)
   __ 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:
   ___ A. Complete Medical Record
   ___ B. Partial Medical Record:
   Period(s) of hospitalization or treatment from: _____ /_____ /_____ to _____ /_____ /_____
   [ ] In-patient Hospitalization [ ] Outpatient Treatment [ ] Ambulatory Surgery [ ] ER

   __ Discharge Summary
   __ History & Physical Examination
   __ Progress Notes
   __ Consultation Reports
   __ Operative Reports
   __ Radiology Reports
   __ Laboratory Tests
   __ Clinic Visit; specify clinic name _____
   __ 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:

_____

_____

_____

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
Department of Health Information Management
Correspondence Unit- Box #119
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