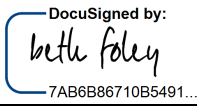


Emma Eccles Jones College of Education & Human Services

POLICY INFORMATION

Document # 111	Title: Use & Disclosure of PHI with Authorization	Print Date: 9/13/2016
Revision # 1.0	Prepared by: J. Black	Date Prepared: 1/15/2016
Safeguard: HIPAA	Approved by: Dean Beth E. Foley 	Date Approved: 9/27/2016

I. POLICY STATEMENT

The CEHS Health Care Component (HCC) must obtain a written authorization from a patient prior to using or disclosing PHI for the purposes described in the implementation section of this policy and in the CEHS Notice of Privacy Practices (NPP).

II. DEFINITIONS

See HIPAA Privacy Policy 100

III. AUTHORITY AND RESPONSIBILITIES

CEHS has component units that are listed as a hybrid entity in accordance with USU's HIPAA Hybrid Covered Entity Declaration. Only the health care component (i.e., covered functions) of CEHS must comply with this policy. All references in this policy to "CEHS" shall be construed to refer only to the health care component of CEHS.

IV. PROCEDURES TO IMPLEMENT

Authorization for uses and disclosures of PHI must be obtained for:

1. Uses and disclosures outside of treatment, payment and health care operations, unless otherwise permitted by law or the Notice of Privacy Practices as applicable;
2. Uses and disclosures created for research (when required pursuant to the **HIPAA Privacy Policy - 113 Uses and Disclosures for Research**)
3. Psychotherapy Notes except:
 - a) To carry out treatment, payment, or health care operations:
 - i. Use by the originator of the notes for treatment;
 - ii. Use or disclosure in training programs in which trainees, students, or providers in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling; or
 - iii. Use and disclosure by a facility to defend a legal action or other proceeding brought on by the individual.
 - b) Use and disclosure with respect to oversight of the originator of the notes. "Psychotherapy notes" means: notes recorded (in any medium) by a physician or clinician who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or

Emma Eccles Jones College of Education & Human Services

family counseling session that are separated from the rest of the individual's medical record. Psychotherapy notes excluded medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items; diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.

Valid Authorization Requirements - (See **Attachment A - Authorization for Release of Protected Health Information**). If the authorization is valid, the HCC must disclose PHI in accordance with the authorization, unless the HCC is prevented from doing so by state or federal law. A valid authorization to release PHI must be written in plain language and include all of the following core elements and required standards:

1. Description of PHI to be disclosed
2. Name of person/entity permitted to send PHI
3. Name of person/entity permitted to receive PHI
4. Purpose for disclosure
5. Expiration date
6. Statement regarding right to revoke
7. Statement regarding conditions to authorization
8. Re-disclosure of PHI
9. Signature of patient or patient representative
10. Description of representative's authority
11. Date of authorization

Invalid Authorizations - If an invalid authorization is received, the HCC must identify why it is invalid and return it to the requestor for completion or correction. An authorization is invalid and cannot be acted upon if any of the following are true:

1. The expiration date has passed;
2. The authorization has not been filled out completely or correctly;
3. The HCC knows the authorization has been revoked by the individual;
4. The HCC knows material information in the authorization, in whole or in part, is false or fraudulent, or not properly executed;

Who May Request Release of PHI

1. A patient may request use and/or disclosure of his/her PHI (Note: Authorization is not required for HCC to use and/or disclose PHI for those activities described in **HIPAA Privacy Policy 109 - Use and Disclosure of PHI for Treatment, Payment and Health Care Operations** and **HIPAA Privacy Policy 110 - Use and Disclosure of PHI Without Authorization**).
2. The individual's personal representative, as determined under law, may authorize the use and/or disclosure of individual's PHI. Proof of the personal representative's authority to act on behalf of the individual must be provided and verified.

Emma Eccles Jones College of Education & Human Services

3. The HCC may request that the patient/representative sign an authorization. If the HCC seeks an authorization from an individual for a use or disclosure of PHI, the HCC must provide the individual with a copy of the signed authorization.

Verification

The identity of the person signing the authorization must be validated. Methods of validation include reference to a picture ID, such as a driver's license or passport, or comparison of signatures documented in the patient's PHI records.

Prohibition for Conditioning Treatment

The provision of treatment to an individual may not be conditioned on signing an authorization except for:

- a) Research-related treatment; and
- b) Health care that is solely for the purpose of creating information for disclosure to a third party

Compound Authorizations Prohibited

An authorization for use of PHI may not be combined with any other document to create a compound authorization, except as follows:

1. In accordance with **HIPAA Privacy Policy 113 - Uses and Disclosures for Research**, an authorization for the use and disclosure of PHI created for research may:
 - a) Be combined with any other type of written permission for the same research study, including another authorization or a research informed consent;
 - b) Combine conditioned and unconditioned authorizations for research as a single document, so long as the authorization clearly differentiates between the conditioned and unconditioned research components and clearly allows the individual to opt in to the unconditioned research activities; and
 - c) Include future research as a purpose of the research authorization, so long as the IRB, in its discretion, determines that h future purposes have been described in such a way that an individual would understand that his or her PHI could be disclosed for future research.
2. Psychotherapy Notes - an authorization for use and disclosure of psychotherapy notes (as defined by HIPAA) may only be combined with another authorization for the use or disclosure of psychotherapy notes. (See **HIPAA Privacy Policy 112 - Use and Disclosure of Psychotherapy Notes**).

Revocation (See **Attachment B - Revoke Authorization for Use and Disclosure of Protected Health Information**)

1. An individual may revoke an authorization in writing at any time. The revocation must be in writing, submitted to the HCC Privacy Officer, and specify which authorization is revoked.

Emma Eccles Jones College of Education & Human Services

2. Upon receiving the request to revoke, the HCC must discontinue any further release of the patient's PHI as permitted by the initial authorization, but the revocation does not apply to actions previously taken by the HCC in reliance on the initial authorization.

Retention

1. Every signed authorization must be documented and retained for a minimum of six years from their last effective date, or longer if required by state law.
2. Authorizations and revocations of authorizations must be filed in the patient's records.

V. ATTACHMENTS

Attachment A - Authorization for Use and Disclosure of Protected Health Information (PHI)

Attachment B - Revoke Authorization for Use and Disclosure of Protected Health Information (PHI)

VI. REFERENCES

45 CFR §164.508

HIPAA Privacy Policy 109 - Use and Disclosure of PHI for Treatment, Payment and Health Care Operations

HIPAA Privacy Policy 110 - Use and Disclosure of PHI Without Authorization

HIPAA Privacy Policy 112 - Use and Disclosure of Psychotherapy Notes

HIPAA Privacy Policy- 113 - Uses and Disclosures for Research

Emma Eccles Jones College of Education & Human Services

Attachment A

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

Please check type of information to be used or disclosed:

<input type="checkbox"/> Medical Record ___ Evaluation ___ Chart Notes ___ All	<input type="checkbox"/> Itemized Bill	<input type="checkbox"/> Other (specify):
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Please note any conditions or limitations to this authorization: _____

I hereby authorize (HCC Name) to (check all that apply):

<input type="checkbox"/> Exchange information with	<input type="checkbox"/> Release information to	<input type="checkbox"/> Obtain information from
--	---	--

Purpose of Request:

<input type="checkbox"/> Treatment or consultation	<input type="checkbox"/> At the request of individual <input type="checkbox"/> Other _____	<input type="checkbox"/> Billing or claims payment <input type="checkbox"/> CEHS Healthcare Operations
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Expiration Date of Authorization: This authorization is effective through ____/____/____ unless revoked or terminated by the patient or patient’s representative.

The following Organization/Individual in regard to the above named patient:

Name of Person/Organization

Address City State Zip Code

Phone Number Fax Number

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written request to (HCC NAME/ADDRESS HERE). You should contact the Clinic Privacy Officer for the Revocation Request form. If you do revoke the authorization, it will have no effect on any actions taken prior to receiving the revocation.

Potential for Re-Disclosure: You need to be aware that information that is disclosed under this authorization could potentially be disclosed again by the person or organization receiving this information. The privacy of this information may not be protected under the Federal Privacy Regulations under these circumstances.

You may refuse to sign this authorization, signing is strictly voluntary and your treatment will not be affected by your refusal to sign.

Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release: If my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV/AIDS, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:** ___ Yes ___ No _____ Initials

Signature: _____ Date: _____

Relationship to Patient _____ Printed Name of Patient Representative (if different): _____

For office use only:

Processed By:	Date Processed:	Verification type:
		<input type="checkbox"/> DL/other state photo ID <input type="checkbox"/> Signature verification <input type="checkbox"/> Other (Specify): _____

Emma Eccles Jones College of Education & Human Services

*** Original to patient chart, copy to patient

Attachment B

{CLINIC LETTERHEAD HERE}

REVOKE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	Birth Date:	MRN:
Address:		Telephone #:

I hereby REVOKE authorization from: _____

to release the health information of: _____

to _____

that was granted for the purpose of: _____

Type of access that was granted:

<input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Itemized Bill <input type="checkbox"/> Other: _____

Signature of Patient/Guardian/Patient Representative: _____

Printed name: _____

Relationship to patient: _____ Date: _____

Office Use Only

Processed by:	Date Processed:	Verification Type:
		<input type="checkbox"/> DL/other state photo ID <input type="checkbox"/> Signature verification <input type="checkbox"/> Other (Specify): _____