

PROCEDURE DRAFT Authorization

	DATES
<i>Replaces:</i> <i>East –</i> <i>West -</i>	<i>Effective:</i> <i>Designated Review:</i>

PURPOSE

To establish guidelines for processing the Patient's right of disclosure regarding their medical records.

INTRODUCTION

To ensure compliance with the Privacy Standard 164.508 per 45 CFR standards 160-164, Per Health Insurance Portability and Accountability Act (HIPAA) have been established. Patients or authorizations will be directed to the Health Information Management Department (HIM).

SCOPE

Health Information Management
Medical Center Staff

EQUIPMENT/SUPPLIES/RESOURCES

"Authorization for Release of Medical Information" (Form #)
"Revocation of Authorization" (Form #)

STEPS

A Definitions:

1. Authorization is the permission a patient or his legal representative grants to disclose information from the designated record set that is not otherwise required to be disclosed. It is sometimes referred to as "Authorization for Release of Information". Authorizations must be obtained prior to disclosing information outside of the hospital. Disclosure of patient information is done for follow up treatment, insurance, legal proceedings, personal or other specified external entity requests.
2. Designated Record Set is defined as:
 - a) the medical record
 - b) the financial record
3. Protected Information includes Patient Name, Address, Social Security Number, Medical Record Number and Patient Account Number, Date of Birth, all information gathered at registration and during diagnosis and treatment of the patient.

B. Content Requirements:

1. A specific and meaningful description of the information to be used or disclosed.
2. The name or other specific identification of the person(s) or class of persons authorized to make the disclosure.
3. The name or other specific identification of the person(s) or class of persons to whom the covered entity may make disclosure.

4. An expiration date or event that relates to the individual for the purposes of the use or disclosure.
5. A statement of the individual's right to revoke the authorization in writing.
6. A statement about the exceptions to the right to revoke.
7. A description of how the individual may revoke the authorization.
8. A statement that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the rule.
9. Signature of the individual.
10. Date
11. If the Authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual.

C. Procedure:

1. For patients or their representatives:
 - a) HIM is responsible for releasing patient information from the medical record and PFS defined designated record set with a valid authorization and therefore maintains the forms.
 - b) The individual seeking disclosure of information must call or visit the HIM Department, Release of Information (ROI) section at which time they can:
 - Request that a blank authorization form be sent to them to complete and return.
 - Complete the form.
 - c) The completed authorization will be assessed for validity. If any of the following exists it is considered invalid:
 - The expiration date or event has passed.
 - The form has not been filled out completely.
 - If it is known by HIM to be revoked.
 - If it lacks one or more of the required elements.
 - If it is combined with other requests – this is considered a compound authorization (i.e. research).
 - If any information in the authorization is known to be false.
 - d) The legality of the individual signing the authorization is the responsibility of the ROI staff member to assure either by asking for identification or comparing signatures on the authorization with those on the medical record.
 - e) The staff member who witnesses the signature (if in person) will sign as the witness and give a copy of the authorization form to the person signing.
 - f) The patient may elect to take advantage of their right to inspect the record or documents that will be sent. The ROI staff member should give the patient or his/her representative a date when the copies will be ready and set a time that they may come in to inspect and receive them.
 - g) The authorization is retained according to the hospital's retention period for medical records (30 years).
2. By another covered entity (i.e.; Insurance Company, Care Provider):
 - a) HIM's ROI section frequently receives written or faxed requests for information with an authorization from that entity.
 - Assure all content requirements listed in B above are present
 - Assure validity according to C.1.c. above.
 - The patient or entity must be contacted if elements are missing.

D. Exceptions: When a patient's information may be released without an authorization:

- Billing purposes – covered in "Consent for Use and Disclosure for Treatment, Hospital Operations and Billing". This includes copies needed by an Insurance Company to pay the hospital bill.
- When required by law in situation involving victims of abuse, neglect or domestic violence, crime committed on premises or against personnel.
- Public Health Purposes
- When required by health oversight activities.
- Judicial proceedings.

- Law enforcement purposes.
- Certain purposes required by coroners, medical examiners and funeral directors
- Organ donor purposes, relating to cadaver.
- Medical research purposes.
- When necessary to prevent or lessen a service or imminent threat to the health or safety of a person or the public.
- For certain military and government purposes.
- To comply with worker compensation.

Expectations:

- It is expected that the HIM's ROI section will release this information.
- For the purpose of tracking an authorization form will be filled out by the ROI staff member with the "other" section on #2 on the form checked an notation at bottom will be made for clarification purposes.

E. When _____ requests patient information for its own uses that is not covered in the Notice of Information Practices.

A cover letter to the patient must:

- Assure that further treatment is not conditional upon them signing the authorization.
- Describe the purpose of the requested use or disclosure.
- A statement that the individual may inspect or copy the information to be used or disclosed.
- A statement that the individual may refuse to sign the authorization.
- A statement that _____ may be remunerated by a third party.

If this is to happen:

- The patient must be provided a copy of the authorization.
- A statement that the individual may refuse to sign the authorization.

F. Research

An authorization to use and disclose patient information created for research that includes treatment may be in the same document as:

- A consent to participate in the research
- A consent to use and disclose patient information to carry out treatment, payment or healthcare operations.
- A Notice of Information Practices

G. Revocation of an Authorization

1. A patient may revoke an authorization at any time by completing the appropriate form. Exception is if the authorization was obtained as a condition of obtaining insurance coverage.
2. The signed Revocation form must be acted upon immediately by ROI section in HIM.
 - Determine if there are any outstanding requests and follow the guidelines designated by the patient.
 - Indicate revocation date on the authorization form.
 - File on chart.
 - Send a copy to _____ who must respond in writing to patient within 15 working days.

H. Authority to Grant Authorization

The authority to grant authorization for disclosure of health information resides with:

- The patient, if the patient is a competent adult (Nebraska age is 19 years old) or an emancipated minor;

- A legal guardian or custodial parent or parent on behalf of a minor;
- A power of attorney for health care;
- The executor of the estate or a court appointed individual, if the patient is deceased.

An emancipated minor is defined as a minor who is one or more of the following:

- Married;
- Self-supporting and living away from home;
- Unmarried and pregnant
- At least 16 years old and living independently from parents or guardian
- On active duty with the U.S. Armed Forces; or
- Declared legally emancipated by a court of law.

If the patient is incompetent or otherwise unable to authorize disclosure, the following individuals may serve as the patient’s legal representative, in order of priority:

- Legal guardian or attorney ad litem
- Agent named in durable power of attorney for healthcare in a court directive
- Next-of-kin, in the following order; spouse, adult child, parent, adult siblings

In the event of a patient’s death, the legal representative or the executor of that patient’s estate is the person who can authorize the disclosure of health information. If there was a durable power of attorney appointed by the patient, that person loses all right to the record after the patient is deceased. If there isn’t an executor of the estate, next-of-kin can authorize disclosure of information in the following order; spouse, adult child, parent, adult siblings.

REFERENCES

Federal Register

“HIPAA Made Simple: A Practical Guide to Compliance” by Margaret Amatayakul, 2001.

AUTHOR

Approved by: Privacy WorkGroup; HIPAA Advisory Team; Information Management Function Team

KEYWORDS

HIPAA

Privacy

Authorization

SIGNATURES (Signature Sheet on File)

DATES:

Effective:

Previous Review:

E:

W:

Designated Review

I authorize _____
Name and Address

to release the following information on _____
Patient's Name and Date of Birth

to: _____
Name and Address

1. **Date(s) of Treatment:** _____ **Information to be Disclosed:**
- | | | |
|--|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Lab and X-ray Report |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> History and Physical Examination |
| <input type="checkbox"/> X-ray Films | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> School Assignment and Transcription |
| <input type="checkbox"/> After Care Plan | <input type="checkbox"/> Team Staffing Plan | <input type="checkbox"/> Complete Record |
| <input type="checkbox"/> Chemical Dependency Evaluation Assessment | | <input type="checkbox"/> Financial Record |
| <input type="checkbox"/> Other (specify): _____ | | |

2. **Purpose for which information is to be used:**
- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Follow-up | <input type="checkbox"/> Legal Proceedings | <input type="checkbox"/> Other (specify): _____ |

3. **If this authorization applies to treatment for any of the following condition(s), please initial:**
- | | |
|--|----------------------------------|
| ____ Chemical Dependency or Abuse | ____ Alcoholism or Alcohol Abuse |
| ____ Infection with Human Immunodeficiency Virus (HIV) | ____ Sickle Cell Anemia |
| ____ Mental Health Records | |

4. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my written permission to revoke this authorization it will automatically expire: _____ after six (6) months from date of signature or upon satisfaction of the need for disclosure or as specified:

5. I hereby release _____ from all legal liability that might arise from the release of sensitive information and/or infection protected titles 42 or 38 of the Code of Federal Regulations. **Any further disclosure of my records other than what is outlined above is prohibited without my specific written authorization, or as otherwise permitted by such regulations.** I consider a photocopy of this authorization to be as valid as the original.

6. I understand that I may inspect the information to be disclosed as provided in 45 CFR 164.524. Authorization must be signed by the patient or legal guardian of the patient, or other authorized representative. If the patient is unable to give authorization, or physically sign, state reason:

7. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by this rule. Authorization must be signed by the patient or legal guardian of the patient, or other authorized representative. If the patient is unable to give authorization, or physically sign, state reason:

Patient or person authorized to sign for patient/relationship

Date/Time

Witness to signature only

Person disclosing records

**AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION - DRAFT**

*Original – Medical Record
2/27/02*

Yellow – Patient/Designee

I _____, submit this form as a

Notice to _____ to revoke the authorization I previously submitted on

_____. This is to become effective on _____.
(Date) (Date)

For any pending or future requests based on the terms of that authorization I understand that:

- _____ will respond by stating that they do not have a valid patient authorization
- If the request is for payment of services already received, or to the extent that _____ has taken action on the reliance of the authorization, _____ cannot abide by this.

(Patient or Legal Representative)

(Date)

(Witness to Signature)

Revocation of Authorization - DRAFT
(See Separate Revocation of Consent)

Original – Medical Record

Yellow – Patient/Designee

3/6/02