HAWAII HEALTH SYSTEMS CORPORATION *"Quality Healthcare For All"*	Department: ***Quality Through Compliance***	Procedure No.: **CMP 0029B**
		Revision No.: **1**
PROCEDURE	Issued by: Audit and Compliance Committee	Effective Date: September 19, 2013
Subject: **HIPAA Authorizations for Use and Disclosure of Protected Health Information**	Approved by: Alice M Hall By: Alice M. Hall Acting President & CEO	Supersedes Policy: CMP 019A (8/16/12) Page: 1 of 3

Last Reviewed: August 19, 2013. Next Review: August 19, 2016

I. PURPOSE: This Policy defines the circumstances under which an authorization is necessary prior to use or disclosure of an individual's protected health information ("PHI") and provides the requirements of a valid authorization.

II. PROCEDURE:

A. The following procedure must be followed by HHSC facilities:
   1. Record the receipt date on the authorization.
   2. Inspect all authorizations for the following:
      a) Required Elements and Statements:
         i. Name or description of person or class of persons authorized to disclose PHI.
         ii. Name of person (and other identifying information as necessary to identify the person) whose PHI is to be disclosed.
         iii. Description of the PHI to be used and/or disclosed.
         iv. Name or other identification of the person or class of persons authorized to receive the PHI.
         v. An expiration date or event.
         vi. Purpose of the request
         vii. Signature of patient or legal representative.
         viii. If person other than patient signs the authorization, a description of that person's authority to act on the patient's behalf (see policy on Personal Representatives).
         ix. Date of signature
         x. A statement of the following:
            a. The individual's right to revoke the authorization.
            b. Exceptions to the right to revoke the authorization.
            c. A description of how the individual may revoke the authorization.
            d. Information released may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.

e. Treatment, payment, or continued enrollment in a health plan or eligibility for benefits will not be conditioned upon the individual's provision of the authorization (except as permitted for by law or rule).
f. If for marketing, a statement relating to remuneration to HHSC.
g. If for sale of PHI, a statement that the disclosure will result in remuneration to HHSC.

b) Validity of Authorization:
   i. All required elements and statements are present.
   ii. The expiration date or event has not passed.
   iii. The authorization has not been revoked.
   iv. None of the material information is false (to the best of your knowledge).
   v. The authorization is not combined with another document except that:
      a. Authorizations may be combined with each other except where a provider or health plan has conditioned the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on any of the combined authorizations.
      b. Authorizations for research can be combined with the research's informed consent form or another authorization related to that research,
      c. An authorization for the use/disclosure of psychotherapy notes may only be combined with another authorization for a use/disclosure of psychotherapy notes.

c) A FAX authorization for disclosure of PHI is acceptable if it contains the essential elements of a written authorization. Whenever possible, the original authorization should be obtained.

d) If the authorization does not include the necessary elements, inform the requestor by letter (Attachment A).

e) Once a valid authorization is obtained, research the Medical Record Index, and Electronic Medical Record (EMR) system if available, to determine if records exist for the patient and where they are located. Type and location of records may be noted on the authorization.

f) If records do not exist, notify the requestor of No Records status. Document the date of notification and who was notified on the authorization and then file in the No Records file or EMR system as appropriate.

g) If records are found, log the request into the Release of Information (ROI) tracking system and/or EMR system as appropriate.

h) Preparation of Records:
   i. If authorization includes request for billing records, notify the billing office.
   ii. Retrieve medical records and scan records for the following:
      a. Entries complete.
      b. If records incomplete, notify requestor of record status. Determine if available pertinent parts are sufficient. If not, send what is complete and follow-up with additional information as it is completed. For stat requests, contact appropriate personnel to complete record, as necessary.
      c. Only records pertinent to that patient are in chart.

   iii. Review record for presence of federally protected documentation:
      a. Psychotherapy notes (as defined in Policy CMP029A)
      b. Records and information of federally assisted alcohol abuse and drug abuse programs (as defined in 42 CFR Part 2), including clinicians or departments who hold themselves out as providing diagnosis, treatment or referral for treatment in this area. **NOTE: This information shall be released only with patient's specific authorization, or a court order specifically authorizing such release.**
      c. If record contains any of the above federally protected documentation, check that authorization specifically mentions release of that specific protected information.

   iv. For mental health records, unless the request is from a health care professional or entity for purposes of continuity of care, obtain the treating mental health professional's approval to release the records as follows:
      a. Complete Attachment B - Clinician's Approval for Release of Mental Health records
      b. Route form to the attending mental health professional.
      c. If that person is no longer available, route to chief psychologist.
      d. Psychologist will review records and indicate on form what may be disclosed.
      e. Once records and form received, disclose only what is approved.
      f. Attach Approval form to authorization.

v. Clip or otherwise designate portions to be duplicated in accordance with what information is specifically requested by the authorization, but Do not duplicate:
   a. Specially protected information that does not have appropriate authorization or approval.
   b. Records from other facilities, unless identifiable by HIM department as having been relied on during course of treatment at facility.

vi. If request is for billable copies/duplication, calculate the cost of duplicating the records or placing them on electronic media (if requested and available).

vii. Duplicate or coordinate duplication of the record (in paper or on electronic media as requested and available).

viii. Create invoice for billable copies/duplication.

i) Submission of records:
   1. Mail duplicated records with invoice enclosed.
   2. Complete documentation of release of records in the ROI tracking system and/or EMR as appropriate.
   3. File the authorization and any related paperwork in the patient's medical record on the left side of the folder, or in EMR system as appropriate.

III. APPLICABILITY: All HHSC facilities, HHSC staff, regional and corporate boards

IV. REFERENCE: HHSC Policy CMP 029A

V. ATTACHMENTS: Attachment A - Notification of an Invalid Authorization

Attachment B - Clinician's Approval for Release of Mental Health Records

Notification of an Invalid Authorization

Date

RE:

To Whom It May Concern:

Medical records cannot be released pursuant to your request on the above named individual, as the authorization is not valid according to the HIPAA Privacy Rule, specifically 45 C.F.R. Section 164.508.

The Privacy Rule requires that a valid authorization include specific elements. The following are missing from your authorization.

A. Name of the person or class of persons authorized to release the information.

B. Name of the patient whose records are to be released.

C. Name of person or class of persons receiving the information.

D. Description of the information to be released.

E. Expiration date or event (by hospital policy must be within last 6 months).

F. Description of the purpose(s) for which the information was requested.

G. Signature of the patient.

H. If signed by the patient's personal representative, a description of that person's authority to sign on the patient's behalf.

I. Date of signature.

J. A statement of the patient's right to revoke the authorization.

K. A description of how the patient can revoke the authorization.

L. A statement of any exceptions to the patient's right to revoke the authorization.

M. A statement that information released may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.

N. A statement that treatment, payment, continued enrollment in a health plan or eligibility for benefits will not be conditioned upon the individual's provision of authorization (excepted as allowed by the federal and/or state law).

O. If authorization is for the purpose of marketing and the entity will receive direct or indirect remuneration from the marketing, a statement that remuneration is expected.

P. If authorization is for the purpose of a disclosure of PHI which is a sale of PHI, a statement that the disclosure will result in remuneration to the covered entity.

Please re-execute your authorization to include all the indicated elements. I have included our hospital authorization, which, if completed fully, will meet the requirements.

If you have any questions, please feel free to contact me at _____.

Thank You,

_____
Name/Title

Enc: Copy of Authorization

Appendix B

Clinician's Approval for Release of Mental Health Records

TO: _____

FROM: _____, Title, extension number
_____ Department

DATE: _____

RE: CLINICIAN'S APPROVAL FOR RELEASE OF MENTAL HEALTH RECORDS

Patient Name / Medical Record Number: _____

Contact Number: _____

♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦ **REQUEST** ♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦

DATE REQUEST RECEIVED:

RESPONSE DUE BY:

PURPOSE OF REQUEST:

TYPE OF REQUEST: ___Subpoena ___Attorney ___Physician
___Insurance ___Family ___Other ___DDB/SSI

REQUESTED BY: Name: _____

Phone #: _____

Psychotherapy Notes kept separately from medical or billing records will not be released to the patient who is the subject of such Notes. 45 CFR 164.524. Denial of access to Psychotherapy Notes on this basis is not reviewable. Facility's reliance on clinician's recommendation to deny requests for other mental health treatment records is reviewable* or unreviewable** under 45 CFR 164.524, depending on the reason therefor.

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_____ **DENIED** **Please choose one or more of the following:**

☐ Release of the requested records is reasonably likely to present a danger to the life or physical safety of the patient or another person.*

☐ The record contains information about another person and release of the information is reasonably likely to cause substantial harm to that person. *

☐ Although the requestor has the legal right to ask for the patient's information, release of the information to the requestor is reasonably likely to cause harm to the patient or someone else.*

☐ Patient is requesting psychotherapy notes pertaining to him/herself.**

☐ Patient is a correctional institution inmate and release of the requested records would jeopardize health, safety, security, custody, or rehabilitation of patient or other inmates, or safety of institution or transport staff.**

☐ Patient is a research participant and access to research records has been suspended.**

☐ The information requested was obtained from a non-healthcare provider under a promise of confidentiality and releasing it would be reasonably likely to reveal the source of the information.**

☐ OTHER (please specify) _____

_____

_____ **APPROVED FOR RELEASE OF THE ENTIRE CHART (if requested)**

_____ **APPROVED FOR THE RELEASE OF THE FOLLOWING DATA *ONLY*:**

INPATIENT	OUTPATIENT	DATES	REPORT
____	____	_____	Consult
____	____	_____	Evaluation
____	____	_____	Progress Notes
____	____	_____	Discharge Summary
____	____	_____	Test Report
____	____	_____	Raw Data
____	____	_____	_____

_____ _____

PSYCHIATRIST OR PSYCHOLOGIST **DATE**