HAWAII HEALTH SYSTEMS CORPORATION *"Quality Healthcare for All"*	*Quality Through Compliance*	Policy No.: **CMP 0054A**
		Revision No.:
POLICY	Issued by: Audit and Compliance Committee	Effective Date: October 17, 2013
Subject: **Providing Electronic Protected Health Information (ePHI) to Patients.**	Approved by: Carol VanCamp HHSC Board of Directors By: Carol A. VanCamp Its: Secretary/Treasurer	Supersedes Policy:
		Page: 1 of 2

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

I. **PURPOSE:** This Policy establishes the requirement of Hawaii Health Systems Corporation (HHSC) facilities to provide, upon request, a patient their protected health information (PHI) in an electronic format (ePHI) and requires that the patient sign a form acknowledging receipt of the ePHI and waiver of liability for HHSC against loss of the ePHI provided.

II. **DEFINITIONS:**

Protected Health Information (PHI) — Any information, identifiable to an individual, including demographic information, whether or not recorded in any form or medium that relates directly or indirectly to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Electronic Protected Health Information (ePHI) – Protected health information provided to a vendor or patient in an electronic form such as disk, thumb drive, or email.

III. **POLICY:**

A. HHSC facilities will, upon request from the patient, provide the patient with her/his PHI in an electronic format such as a disk, CD, thumb drive, or via encrypted email.

B. Patient will receive the ePHI in an unencrypted form except when conveyed via email initially from HHSC facility.

C. Patient will sign a form: a) acknowledging receipt of the ePHI and b) waiving HHSC of liability for any subsequent loss or transmission of the PHI from the electronic version provided to the patient.

D. HHSC facilities may charge the patient fees for the provision of the ePHI as set forth in HHSC policy ADM 0001A.

IV. **APPLICABILITY:** This Policy applies to all HHSC facilities.

V. **AUTHORITY:** Standards for Privacy of Identifiable Health Information (HIPAA), 45 CFR, Subtitle A, Subchapter C, Section 164.512(h).

VI. **ATTACHMENTS:** "Acknowledgement of Receipt of ePHI" form

HAWAII HEALTH SYSTEMS CORPORATION
Quality Healthcare For All

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary.

*PATIENT NAME:_____ *DATE OF BIRTH:_____

AKA: _____ *Address:_____

Telephone: Work:_____ Home:_____ Mobile:_____

1. *Complete this section:

This information is to be disclosed for the purpose of:
- ☐ Physician Follow-up
- ☐ Insurance
- ☐ Legal Purpose
- ☐ Patient Request
- ☐ Other: (specify): _____

Facility:_____

I request the following format:
- ☐ Review Only – fees apply
- ☐ Paper Copy – fees apply
- ☐ Electronic Copy (non-encrypted) – fees apply
- ☐ Submit to Another Provider: _____
  - Provider Address: _____
  - City: _____ State: _____ Zip: _____ Phone #: _____
- ☐ Other (please specify): _____

2. * Select from the following (check as many as apply) for services provided during the period of _____/_____/_____ to _____/_____/_____

☐ Billing Records	☐ History and Physical Examination	☐ Treadmill Reports
☐ Complete record (add'l fee may apply)	☐ Laboratory Reports	☐ Verification of Birth
☐ Consultation Reports	☐ Operative Reports	☐ X – ray Reports
☐ Discharge Summary	☐ Pathology Reports	☐ X – ray Films
☐ Echocardiogram Reports	☐ Photography, Videotapes, Digital or other images	☐ Other (please specify):
☐ EKG Reports	☐ Psychotherapy Notes ** (separate authorization req'd)	_____
☐ ER Reports	☐ Progress Notes	_____

3. **ALCOHOL AND/OR DRUG ABUSE RECORDS:** The patient records and information of certain alcohol abuse and drug abuse programs (as defined in 42 CFR Part 2) are specially protected under federal regulations and will not be released without my specific authorization. By initialing here _____, I hereby specifically authorize the facility to release any such records contained within my HHSC record.

4. I understand if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

5. The facility, its employees, officers and physicians are released from any legal responsibility or liability for releasing the requested information as authorized.

6. My initials indicate that I have read and agree to the following:

   a. Initials:_____ I understand this authorization will expire six months from the date signed below or upon the following event or condition _____, unless revoked earlier.

   b. Initials:_____ I understand I may revoke this authorization at any time by notifying this facility in writing. I also understand that revoking this authorization will not apply to any information already released by this facility before they received the revocation. (See our Notice of Privacy Practices for Instructions).

   c. Initials:_____ I understand that the provider/facility reserves the right to collect reasonable fees for the copies I have requested.

7. I hereby release the Hawaii Health Systems Corporation and its affiliates ("HHSC") from all liability and all claims of any nature whatsoever pertaining to the use and disclosure of information, or of any professional opinions, findings, or recommendation as contained in the records released to or by HHSC. I understand that HHSC is NOT responsible for lost or misplaced copies (paper copies, CDs, thumb drives etc.), and it is my responsibility to handle them with care.

8. This authorization is voluntary. I understand that I can refuse to sign this authorization and HHSC will not condition my treatment, payment, or enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment; (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

Signature: _____ Print Name: _____ Date: _____ Time: _____
Patient or Personal Representative

Relationship to Patient: _____ Date: _____ Time: _____
(Complete only if requestor is not patient)

Office Use Only:

Witness Signature: _____ Print Name: _____ Date: _____ Time: _____

- Identity of authorized signer verified by: _____State ID _____Driver's license _____Other
- Copy of "designated patient representative" documentation obtained for permanent record (check one): _____Yes _____No

ID verification signature: _____ Print Name: _____ Date: _____ Time: _____

CO0017

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION