



Harris County Hospital District

POLICY AND REGULATIONS MANUAL HIPAA ADMINISTRATIVE POLICY

Authorization for Use and
Disclosure of Protected
Health Information for
Purposes Other Than
Treatment, Payment and
Health Care Operations

Policy No: 3.11.300
Page Number: 1 of 14

Effective Date: 041403
Board Motion No:

TITLE: AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OTHER THAN TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

PURPOSE:

The purpose of this policy is to outline the process for the Use and Disclosure or release of patients' Protected Health Information (PHI) when a patient's Authorization is required.

This policy supports Harris County Hospital District's (HCHD) HIPAA policy and may require development of department specific procedures.

[Key Words: Authorization, Use, Disclosure, Protected Health Information (PHI), Record Custodian, Revocation]

POLICY STATEMENT:

Pursuant to Federal and state privacy laws, Harris County Hospital District will ensure that a properly written and signed authorization by the patient, or his/her representative, for use or disclosure of information is received before the patient's Protected Health Information is used or disclosed for reasons other than treatment, payment, or healthcare operations. An Authorization may be revoked in writing at any time.

POLICY ELABORATION:

I. DEFINITIONS

- A. Authorization - A signed written document that allows Use and Disclosure of PHI for purposes other than Treatment, Payment or Healthcare Operations.



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- B. Compound Authorization – An Authorization for use or disclosure of protected health information that is combined with any other type of Authorization.
- C. Conditioning – Requiring an individual to sign a document or agreement in order to receive services or other benefits.
- D. Disclosure or Release – The release of information outside the facility.
- E. Individually Identifiable Health Information (IIHI) – Information, including demographic information, that:
 - 1. Is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and
 - 2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual; and
 - 3. Identifies the individual; or
 - 4. There is a reasonable basis to believe the information can be used to identify the individual.
- F. Personal Representative is a person with authority under the law to act on behalf of the patient.
- G. Protected Health Information - Individually Identifiable Health Information in any form, including demographic



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information, that is created or received by a healthcare provider, and relates to the patient's healthcare condition, provision of healthcare, or payment for the provision of healthcare.

- H. Record Custodian - An individual designated by the facility to be responsible for the safekeeping, maintenance, and release of PHI.
- I. Use – With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

II. AUTHORIZATION REQUIREMENTS

- A. A valid Authorization must:
 - 1. Be written in plain language.
 - 2. Specify the name of the institution or person that is to use or disclose/release the information.
 - 3. Specify the information that is to be used or released, including sensitive information (i.e.: HIV, AIDS, Drugs, Alcohol and/or mental health).
 - 4. Specify the purpose or need for the information. The statement “at the request of the individual” is a sufficient description of the purpose when the individual initiates the Authorization and does not, or elects not to, provide a statement of the purpose.
 - 5. Specify the individual or institution and address of the entity that is to receive the information.



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6. Specify the patient's full name; last name, first name and any other known names.
7. Specify a date, event, or condition upon which the Authorization will expire (in 180 days unless specified otherwise or revoked).
8. Be signed and dated by the patient or his/her legal representative. If a Personal Representative of the patient signs the Authorization, a description of such representative's right to act for the patient must be included.
9. Contain a statement that the patient has the right to revoke the Authorization in writing along with the exceptions to the right to revoke and a description of how to revoke the Authorization; or refer to the information above included in the Notice of Privacy Practices.
10. Address the ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the Authorization by stating either:
 - a The facility may not condition treatment, payment, enrollment or eligibility for benefits on whether or not the individual signs the Authorization when the prohibition on conditioning of Authorizations in the section of this document titled Prohibition on Conditioning of Authorizations applies; or
 - b The consequences to the individual for refusing to sign the Authorization when, in accordance with the section of this document titled Prohibition on Conditioning of Authorizations, the facility can condition



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treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such Authorization.

11. Contain a statement that information disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) regulations.
12. Be in a stand-alone document (i.e., not combined with other Authorizations or consents), except as outlined in Use of PHI for Research, and Use and Disclosure of Psychotherapy Notes.
13. Contain HCHD requirements, which are listed below:
 - a Specify the date(s) of service for which information is to be disclosed.
 - b Specify the patient's address, date of birth, and social security number.

III. DETERMINING VALIDITY AND PROCESSING THE AUTHORIZATION

- A. The valid Authorization (See Attachment A) must be written and delivered to HCHD in person, via the mail, courier, or facsimile. E-mail Authorizations are not valid.
- B. The Record Custodian or his/her designee will review all Authorizations and determine whether the Authorization is valid, and determine whether the identity of the requestor is valid (See Attachment B for guidance on authorized representatives).



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***All required components of the submitted Authorization must be complete.**

- C. Every reasonable attempt must be made to verify the authenticity of the signature on the Authorization. (Verify the authenticity by comparing the signature on the Authorization form with the signatures within the medical record, the consent for treatment, instruction to the patient, I. D. proof, etc.)
- D. An Authorization is invalid or defective and will not be acted upon if any of the following are true:
1. The expiration date has passed or the expiration event is known by HCHD to have occurred;
 2. The Authorization has not been filled out completely, with respect to an element described in item II. A. 1. through II. A. 13. b above is incomplete or is missing any of the items listed in Section II. A. above required for a valid Authorization;
 3. HCHD knows the Authorization has been revoked by the patient or his/her Personal Representative;
 4. HCHD knows material information in the Authorization is false; or
 5. The Authorization is not a stand-alone document (i.e., the Authorization is combined with any other document such as a Notice of Privacy Practices or written voluntary consent). See the Special Considerations Section at the end of this document for additional information and Policy 3.05, Use of



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Protected Health Information for Research and
Policy 3.11.301 Use and Disclosure of
Psychotherapy Notes.

- E. If an invalid Authorization is received, the Record Custodian, or his/her designee, will identify why it is invalid and return it to the requestor for completion or correction.
- F. If the Authorization is valid and approved, the Record Custodian, or his/her designee, will comply with the terms of the Authorization.

IV. PROHIBITION ON CONDITIONING OF AUTHORIZATIONS

HCHD may not condition the provision of patient treatment or payment on the provision of an Authorization except:

- A. HCHD may condition the provision of research-related treatment on the provision of an Authorization for the use or disclosure of PHI for such research;
- B. HCHD may condition the provision of health care that is rendered solely for the purpose of creating PHI for disclosure to a third party on provision of an Authorization for the disclosure of PHI to such third party, e. g. to obtain a lab test the results of which are for use in making a pre-employment decision.

V. WHO MAY REQUEST A DISCLOSURE OF PHI



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- A. The patient may request release or disclosure of PHI for purposes other than Treatment, Payment or Health Care Operations.
- B. The patient's Personal Representative, as outlined in Attachment B, may request release or disclosure of PHI for purposes other than Treatment, Payment or Health Care Operations. Proof of the Personal Representative's right to the PHI must be provided.
- C. The identity of the requestor will be validated either with a picture ID, such as a driver's license or passport, or comparison of signatures documented in the patient's records.
- D. See Policy 3.11.306, Permitted Use and Disclosure of Protected Health Information Without Authorization, for release or Disclosure of PHI without the patient's or patient's Personal Representative's written Authorization.
- E. See Policy 3.11.105, Use and Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations for a discussion of the HCHD's Uses and Disclosures of PHI without Authorization for purpose of Treatment, Payment, and Health Care Operations.
- F. If HCHD seeks an Authorization from a patient or his/her Personal Representative for a use or disclosure of PHI, HCHD must provide the patient or such representative with a copy of the signed Authorization.



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VI. REVOCATION OF AUTHORIZATIONS

- A. A patient, or his/her Personal Representative, may revoke an Authorization at any time. The revocation must be in writing, submitted to the Privacy Officer or designee, and specify which Authorization is being revoked.
- B. The Privacy Officer, or designee, will notify all designated Record Custodians of the revocation.
- C. The Record Custodian receiving the request to revoke an Authorization must discontinue any further release of the patient's PHI as permitted by the initial Authorization; but the revocation does not apply to actions taken by HCHD in reliance on the initial Authorization.
- D. For insurance purposes: the revocation does not apply if the Authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- E. As appropriate, the Record Custodian will notify other areas of HCHD that may have relied upon the Authorization of the revocation.

VII. WHO MAY RECEIVE AN AUTHORIZATION AND RELEASE PHI

- A. Record Custodians, or their designees, may receive and



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validate a patient's or Personal Representative's
Authorization to release PHI.

- B. Record Custodians, or their designees, may release PHI after receipt and approval of a valid Authorization.

VIII. TIMEFRAME FOR RESPONDING TO AUTHORIZATIONS REQUESTING DISCLOSURE OF PHI

- A. Each Record Custodian will ensure that requests for Disclosure of PHI are provided pursuant to state law.
- B. If a facility is unable to meet the specified timeframe or locate the record, it will notify the requestor of the delay in writing.

IX. FEES FOR COPIES

- A. HCHD may charge reasonable fees to cover the costs of copying and postage.
- B. Each Record Custodian will ensure that fees for copying and providing records are applied in accordance with District policies and applicable state law.

X. RETENTION OF AUTHORIZATIONS AND REVOCATIONS

- A. Authorizations and revocations of Authorization, if



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applicable, will be maintained for six (6) years from their last effective date, or longer if specified in the District's Record Retention and Destruction Policy.

- B. Authorizations and revocations of Authorization, if applicable, will be maintained in the patient's Designated Record Set.

XI. SPECIAL CONSIDERATIONS

- A. An Authorization for Use or Disclosure of PHI other than for Psychotherapy Notes may be combined with any other Authorization to create a Compound Authorization except when HCHD has conditioned the provision of Treatment, Payment, enrollment in the health plan, or eligibility for benefits on the provision of one of the Authorizations.
- B. An Authorization for the use or disclosure of Protected Health Information for a research study may be combined with any other type of written permission for the same research study (See Policy 3.05, Use and Disclosure of PHI for Research).
- C. An Authorization for a use or disclosure of psychotherapy notes may only be combined with another Authorization for a use or disclosure of psychotherapy notes (See Policy 3.11.301, Authorization for Use and Disclosure of Psychotherapy Notes).
- D. Transition Provisions: HCHD may use or disclose PHI that it created or received prior to April 14, 2003 pursuant



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to an Authorization or other express legal permission obtained from the patient or his/her Personal Representative, provided that the Authorization or other express legal permission specifically permits such Use and Disclosure and, there is no agreed to Restriction in effect.

REFERENCES/BIBLIOGRAPHY:

- Policy 3.11.000, HCHD HIPAA Policy
- Policy 3.11.105, Use and Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations
- Policy 3.11.301, Authorization for Use and Disclosure of Psychotherapy Notes
- Policy 3.11.306, Permitted Use and Disclosure of Protected Health Information Without Authorization
- Policy 3.11.601, Use of Protected Health Information for Marketing
- Policy 3.11.602, Use of Protected Health Information for Fundraising
- Policy 3.05, Use and Disclosure of PHI for Research

OFFICE OF PRIMARY RESPONSIBILITY:

Office of Privacy Administration.

REVISION HISTORY:

Record revisions below:

Effective Date	Version	Approved by:

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (Please Print)

Hospital Card Number:			
Patient Name:	Social Security No.	Date of Birth	Phone No.
Address	City	State	Zip Code

I, _____, authorize Harris County Hospital District to disclose and provide photocopies of the health-care information indicated below from my medical record to the following party:

Name of person(s) or company to receive information			Phone Number
Street Address	City	State	Zip Code

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Admission Sheet | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Clinic Visit |
| <input type="checkbox"/> Autopsy | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Footprints | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Radiology Report (X-Ray, MRI, Ultrasound, etc) | _____ |
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Entire Record Excluding Nurses Notes | <input type="checkbox"/> Emergency Room Sheet | _____ |
| <input type="checkbox"/> Itemized Bill | <input type="checkbox"/> Lab / Slides | <input type="checkbox"/> Radiology Film (MRI, chest X-Ray, etc.) | |
| <input type="checkbox"/> Complete Billing Record | <input type="checkbox"/> Block/Specimens | <input type="checkbox"/> Psychotherapy Notes (If this box is checked, no other box may be checked) | |

Purpose of Request/Disclosure

- Treatment or Consultation At the request of the Patient Billing or claims payment Requested for Government Benefit
- Other, (specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my information requested above 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

Re-Disclosure

I understand the information disclosed by this authorization may be subjected to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act 1996. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

This authorization will expire on the following event or date _____ or 180 days from the date of signature. I understand that this authorization may be revoked by the person giving the authorization by written and dated notice to Harris County Hospital District, except to the extent that disclosure of information has been made prior to receipt of the revocation by Harris County Hospital District.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under **Purpose of Request**. I can inspect or copy the protected health information to be used or disclosed.

Signature of Patient _____ Date Signed _____

Authority to Sign if not patient _____

Identity of Requestor Verified via: Photo ID Matching Signature Other, specify _____

A legally authorized representative is defined as follows:

IF THE INDIVIDUAL IS	AUTHORIZED REPRESENTATIVE
1. Competent Adult Patient	Patient
2. An emancipated minor	Patient
3. An un-emancipated minor (single or unmarried under age 18)	A parent, legal guardian, court-appointed guardian ad litem, or attorney ad litem with legal authority to make health care decisions on behalf of the minor child.
In the case of a minor child whose parents are divorced, the parent having legal custody of the child must sign the Authorization.	
4. Incompetent adult patient	A person with legal authority to make health care decisions on behalf of the individual. Example: Durable power of attorney, court appointed legal guardian, guardian ad litem or attorney ad litem.
5. Deceased	A person with legal authority to act on behalf of the decedent or the estate (not restricted to health care decisions). Examples: Personal Representative (Executor or Administrator), surviving parent, spouse or adult child, or agent authorized by patient's durable power of attorney. Required documentation: Either a letter of testamentary or a letter of administration, durable power of attorney, marriage, death or birth certificate establishing relationship to deceased.