



HIPAA Privacy Procedure #5

Effective Date: April 14, 2003
Reviewed Date: February, 2011
Revised Date: March, 2007
Scope: Radiation Oncology

Authorization Required for Uses or Disclosures of Protected Health Information

Policy Expectation:

As a general rule, you must obtain a specific, written authorization from an Individual before Using or Disclosing PHI, for all purposes other than treatment, payment or health care operations or Uses and Disclosures required by law.

Each Individual has a right to receive a copy of their PHI and to be informed regarding his/her rights and Radiation Oncology legal duties with respect to PHI.

Why is this important?

- Compliance with all HIPAA privacy regulations is required of all Radiation Oncology Divisions Using or Disclosing PHI.
- Failure to comply may result in being liable for civil or criminal penalties.

What do you need?

- Copy of the HIPAA Privacy Policy on
 - Authorization Required for Uses or Discloses of Protected Health Information
 - Marketing
 - Media Relations
 - Fundraising
 - Research
 - Access by Individuals to Protected Health Information
 - Uses or Disclosures of PHI without a Verbal or Written Authorization

If the use or disclosure of PHI is NOT for Treatment, Payment, or Health Care Operations, a specific authorization form, which tells what the use or disclosure will be, and to whom it will be made, is required. The authorization must be read, signed and dated by the patient. The disclosures in the authorization cannot be general. Authorization must specifically cover the activity for which the information will be used.

Steps:	Additional Information
<p>1. Determine type of authorization required to meet the request. For example, Marketing. Obtain an authorization.</p> <ul style="list-style-type: none"> • A Patient always has access to their own PHI without authorization or entry into the Disclosure Log. • Disclosures for treatment, payment, or operations do not require authorization. • Any requests required by law do not need an authorization, but a copy of the individual’s subpoena or badge should be placed in the Medical Record correspondence section, and the Disclosure should be listed on the log immediately. • For general use or disclosure of PHI, refer to Attachment A. 	<p>Tell the requester that this request may take up to 30 days to process.</p> <p>Only fundraising personnel execute any authorizations for fundraising.</p> <p>Only research personnel execute any research authorizations.</p> <p>Any revisions in authorization forms require approval by Office of General Counsel.</p>
<p>2. Each Authorization shall be specific to what use or disclosure the patient has listed.</p> <p>3. Authorizations which cover multiple purposes are only of the following type:</p> <p>Authorizations for disclosing psychotherapy notes may be combined together for multiple purposes.</p>	<p>Example: if the patient authorizes release of PHI for a study on migraines, you cannot use that authorization if the researcher begins studying strokes.</p>
<p>4. Place no conditions on authorizations except for the following:</p> <ul style="list-style-type: none"> • Condition research treatment on signing authorization. • Covered entity may condition treatment if services provided are for the sole purpose of a third party (employer physicals, etc). • Health plan may condition benefit eligibility on authorization to disclose to plan. • Health plan may condition payment of claims on authorization to disclose 	<p>For example, if a patient wants to take part in a research study, but won’t sign an authorization – we can deny their participation.</p> <p>If Boeing sends their employee here to have an employee physical prior to hiring them, but the patient won’t sign a release authorizing Boeing to have the results of the physical – we can refuse to see the patient.</p>

5. Review the authorization form with Individual.

- If Radiation Oncology is presenting the authorization for signature for purposes other than treatment, [payment](#) or [health care operations](#), complete the form explaining the purpose and scope of the request.
- Determine the expiration date and enter it on the form.
- Ask [individual](#) or representative if there are any unanswered questions related to the authorization form.

- Explain that the authorization may be revoked at any time with the following exceptions:
 - Where authorization was condition of insurance coverage.
 - Where Radiation Oncology has already taken action based on the authorization

- Provide a copy of the signed authorization form to the person signing the form.

- Store the original document in the place designated by PHI custodian for a period of 6 years from the date of expiration.

- Disclose the authorized information to the original requester.

- Any disclosures must be documented in the Disclosure Log or place designated by PHI custodian.

Include a copy of any research authorization or authorization waiver in the medical record, to identify participant as a research participant, as well as a patient.

CHANGES IN THIS FORM MUST BE APPROVED BY WU LEGAL DEPT

EXHIBIT A
Authorization for the Use or Disclosure of
Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this protected health information may be used and/or disclosed pursuant to this authorization: _____

2. I authorize the following persons (and or class of persons) to make the authorized use and/or disclosure of the specified protected health information: _____

3. I authorize the following persons (or class of persons) to receive my protected health information: _____

4. This authorization expires upon _____
(*insert date or event triggering expiration*).
5. I understand that once my protected health information is used and/or disclosed pursuant to this authorization, it may no longer be protected by the privacy regulations and may be subject to re-disclosure by the recipient(s).
6. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy. I am aware that my revocation is not effective to the extent that I have authorized the use and/or disclosure of my protected health information and such use and/or disclosure has been relied upon by authorized recipients. I also understand that I may not revoke authorized use and/or disclosures obtained in connection with my receipt of insurance coverage.

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THE FOLLOWING PARAGRAPHS APPLY IF AUTHORIZATION IS REQUESTED BY WASHINGTON UNIVERSITY FOR ITS OWN USE:

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Washington University nor will it affect my eligibility for benefits. (*OMIT #7 if the authorization applies to research-related activities, a health plan offering enrollment or eligibility benefits or specialized benefits pre-enrollment, or when Washington University is providing care solely for the purpose of creating PHI for disclosure to a third-party.*)

8. My protected health information will be used or disclosed upon request for the following purposes (*name and explain each purpose*): _____

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the Notice of Privacy.
10. I understand that Washington University will receive compensation for its use and/or disclosure of my protected health information. (*OMIT #10 if not applicable*).

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INCLUDE FOLLOWING PARAGRAPHS (IN ADDITION TO PARAGRAPHS 1-6 ABOVE) IF AUTHORIZATION IS REQUESTED BY WASHINGTON UNIVERSITY FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS:

11. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Washington University, nor will it affect my eligibility for benefits. (*OMIT #7 if the authorization applies to a health plan offering eligibility for specialized benefits*).
12. My protected health information will be used or disclosed upon request for the following purposes (*name and explain each purpose*): _____

I certify that I have received a copy of the authorization.

Signature

Date

Name

Name of Personal Representative

Relationship to Individual

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