

<b>POLICY TITLE:</b> Patient Authorization for Use or Disclosure of Their PHI	
<b>DEPARTMENT:</b> Corporate Responsibility	<b>ORIGINATION DATE:</b> 04/14/2003
<b>CATEGORY:</b> Privacy-HIPAA	<b>EFFECTIVE DATE:</b> 08/26/2011

### SCOPE

This policy applies to all Centura Health facilities, practices, entities and services (“Centura”) and all members of the workforce including, but not limited to, associates, employed physicians, contractors, and volunteers.

### PURPOSE

To ensure appropriate patient authorizations are obtained prior to the use or disclosure of Protected Health Information (PHI). An authorization gives Centura permission to use or disclosure particular PHI to a specified third party for a specified purpose.

### STATEMENT OF POLICY

Centura will obtain a valid authorization from patients prior to Centura’s use or disclosure of their PHI when the use or disclosure is not for treatment, payment or healthcare operations, or as otherwise required by state and federal laws identified in this policy. Centura may only use authorizations that meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. In order for an authorization to be legally valid, it must contain specific components and statements (Attachment A).

Centura will obtain a valid authorization prior to the use or disclosure of PHI in the following circumstances:

- Marketing purposes (see “Use or Disclosure of PHI for Marketing” policy)
- Fundraising efforts other than those through the institutionally related foundations (see “Use or Disclosure of PHI for Fundraising” policy)
- Research-related treatment (see “Use or Disclosure of PHI for Research” policy)
- Disclosure of psychotherapy notes and substance abuse records to third parties
- Disclosure to attorney
- Other uses or disclosures not related to treatment, payment, healthcare operations or pursuant to a state or federal law
- Disclosure in response to a subpoena or discovery request, if Centura is unable to receive satisfactory assurances from the party seeking the information that reasonable efforts have been made to notify the patient of the request (as determined by Centura’s Legal department)

When photographing and/or interviewing patients, residents, family members and visitors, a special “Authorization to be Photographed and/or Interviewed” form (Attachment D) must be obtained.

Centura will not be required to obtain an authorization for the use and disclosure of PHI in the following specific situations subject to state and federal limitations:

- Use or disclosure for public health activities (e.g., vital statistics, immunizations, poison control)
- Use and disclosure, to the extent allowable by law, to coroners, medical examiners and funeral directors of deceased patients

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- Use and disclosure for organ donation to organ procurement entities engaged in the procurement, banking or transplantation of organs
- Disclosure regarding victims of abuse, neglect or domestic violence
- Use or disclosure for external health oversight activities (e.g., accreditation surveys, government audits, licensure)
- Use and disclosure to law enforcement for specific purposes (see “Disclosure of PHI to Law Enforcement” policy)
- Disclosure pursuant to a valid court order (as determined by Centura’s Legal department)
- Use and disclosure in the Facility Directory (see “Disclosure of PHI in Facility Directory” policy)
- Use or disclosure to prevent a serious threat to the health or safety of another person or the public
- Disclosures for workers’ compensation as state law dictates
- Disclosure to pharmaceutical or medical device manufacturers for reporting adverse events or product defects
- Use and disclosure to persons associated with research activities, provided that Centura has obtained documentation that an alteration to the authorization requirement has been approved by an Institutional Review Board (IRB)
- To correction institutions having lawful custody of an inmate, provided Centura receives representations that the PHI is necessary for the provision of healthcare, for the safety of the inmate or others, or safety and security of the institution
- Use and disclosure for specialized government functions (e.g., Department of Defense)

A patient may revoke an authorization at any time by providing a written request for revocation (Attachment C), except to the extent that Centura has taken action in reliance on the authorization or such revocation would interfere with the billing or reimbursement for care provided.

Centura is prohibited from conditioning treatment or payment on the patient executing an authorization, except when the authorization pertains to one of the following:

- Research-related treatment
- Determination of eligibility for benefits or enrollment
- Payment of a claim
- Treatment for the sole purpose of providing information to a third party (e.g., insurance application pre-screening examination)

## **PROCEDURE**

### **Obtaining a Legally Valid Authorization**

1. Provide the appropriate Centura authorization form (Attachment B) to the patient, or the patient’s legal representative, to review and complete.
2. Completed Centura authorization form will be returned to the Health Information Management (HIM)/Medical Records department for processing.
3. If a non-Centura authorization form or letter for disclosure is received, the HIM/Medical Records department will ensure that all required information (Attachment A) is completed on the authorization form and that a signature is obtained. If questions or clarification are necessary, the designated Corporate Responsibility & Privacy Officer will be contacted prior to releasing any PHI. Provide a copy of the authorization to the patient or the patient’s representative.

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4. The HIM/Medical Records department will scan the authorization into the patient's electronic medical record.

**Emergent Situations**

In emergent situations where the patient is unable to provide authorization or exercise the opportunity to agree or object, and there is no personal representative, the facility will contact the designated Corporate Responsibility & Privacy Officer to determine whether the use or disclosure of PHI without authorization is permissible within state and federal laws. If appropriate, an authorization will be obtained from the patient after the emergent situation has been stabilized.

**Revocation of an Authorization**

Patients wanting to request revocation of a current authorization will be directed to the HIM/Medical Records department to:

1. Verify that the revocation request is valid and in written format
2. If the revocation request is not valid, provide the patient with a revocation of authorization form (Attachment C)
3. Indicate which specific authorization has been revoked and is no longer valid within the patient health record

**DEFINITIONS**

N/A

**REFERENCES AND SOURCES OF EVIDENCE**

N/A

**POLICY VIOLATION**

Any workforce member who fails to abide by this policy may be subject to disciplinary action, up to and including termination.

**REVIEW/APPROVAL SUMMARY**

<b>REVIEW/REVISION DATES:</b> 07/26/2011 <i>(Dates in parentheses include review but no revision)</i>	
<b>APPROVAL BODY:</b> Board of Trustees Audit/ Corporate Responsibility Committee	<b>APPROVAL DATE:</b> 08/26/2011

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## ATTACHMENT A COMPONENTS OF A VALID AUTHORIZATION

For both internal and external use and disclosure of Protected Health Information (PHI), a legally valid authorization will contain the following mandatory elements:

- Specific description of what PHI will be used or disclosed;
- Name or other specific identification of the person(s) or category of persons authorized to make the requested use or disclosure of PHI;
- Name or specific identification of the person(s) to whom the facility is authorized and permitted to use or disclose PHI;
- Description of the purpose for the requested use or disclosure;
- Expiration date or event that would indicate a specific date or period of time (e.g., completion of a course of treatment);
- Statement that the patient has the right to revoke the authorization if Centura receives the request in writing, and either: (a) the exceptions to the right to revoke and a description of how the patient may revoke the authorization, or (b) reference to the Notice of Privacy Practices;
- Statement explaining that when information is disclosed based on an authorization, the information may be re-disclosed by the recipient and no longer protected by state and federal privacy standards;
- Patient (or patient's representative) signature and date. If signed by a patient's representative, the authorization must include a description of the representative's authority to act on behalf of the patient;
- Statement that the facility will not make execution of an authorization a condition for treatment, payment, enrollment or eligibility for benefits unless the authorization is mandatory (e.g., research-related treatment);
- For marketing/fundraising purposes only, a statement that specifies whether Centura will receive either direct or indirect remuneration for the marketing communication;
- NOTE: An authorization for use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes.

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## ATTACHMENT B PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth	Last 4 Digits of Social Security Number
Address	City, State, Zip Code	Telephone Number
<b>I hereby authorize the Centura facility listed below so disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.</b>		
Release by: _____ Centura Facility _____ Address _____ City, State, Zip Code	Release to: _____ Organization, Agency, Individual _____ Attn: _____ Address, City, State, Zip Code	
<b>Treatment Date(s):</b> _____ <b>Purpose</b> (circle all that apply): Further Medical Care      Legal      Workers' Comp Insurance      Personal Use      Marketing/Fundraising Other _____	<b>Type of Disclosure Authorized &amp; Delivery Instructions:</b> ___ Provide copies of records to organization/agency/individual ___ Mail records directly to address above ___ Call to pick-up records: _____ ___ Fax records to: _____	
<b>Pertinent Protected Health Information Allowed to be Included</b> (circle all that apply): Discharge Summary      Radiology      Special Studies      Entire Medical Record H&P/Consult      Outpt Record      Medication Records      Psych Health Reports Operative Report      Progress Notes      Labs      Physician Orders Other (specify): _____		
<b>Authorization:</b> I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management/Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.  I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility & Privacy Officer.  <b>Expiration:</b> Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here: _____.  <b>Acknowledgement:</b> I understand that the information to be disclosed may include any and all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).  <b>For Marketing/Fundraising Purposes Only, if applicable:</b> I understand that Centura Health will ___ will not ___ receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.		

<b>SIGNATURE:</b> _____ Patient (Parent or Legal Guardian)	<b>DATE:</b> _____
Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado law. <i>Relationship (if other than patient):</i> _____      Power of Attorney _____      Death Certificate _____ <i>Name of individual signing on behalf of patient:</i> _____	
<b>Verification:</b> ___ Drivers License # _____      Other Appropriate ID: _____	
<b>OFFICE USE ONLY: Attach copies of required identification.</b> Number of pages released: _____      Completion date: _____      Delivery method: _____ Name of individual who received request: _____      Date received: _____ Patient Medical Record Number/Account Number: _____ / _____	

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**ATTACHMENT C  
REVOCATION OF PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

Patient Name	Date of Birth	Last 4 Digits of Social Security Number
Address	City, State, Zip Code	Telephone Number

**By signing below, I request the revocation of the prior authorization for the use or disclosure of my protected health information as described herein.**

List authorization(s) including the prior use(s) and/or disclosure(s) of the information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Person(s) or organization(s) originally authorized to receive the information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date(s) of treatment to be released: \_\_\_\_\_

Original date of request for the authorization: \_\_\_\_\_

**I understand that uses and disclosures of my Protected Health Information (PHI) may have been made in reliance upon my previously signed Patient Authorization to Disclose Protected Health Information form. I further understand that this revocation does not apply retroactively and will not affect any actions taken prior to receipt of this request.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
Patient (Parent or Legal Guardian)

Name of individual signing on behalf of patient: \_\_\_\_\_

Relationship (if other than patient): \_\_\_\_\_

<b>OFFICE USE ONLY</b>	
Name of individual who received request: _____	Date received: _____
Patient Medical Record #/Account #: _____ / _____	Completion date: _____

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**ATTACHMENT D  
PATIENT AUTHORIZATION TO BE PHOTOGRAPHED AND/OR INTERVIEWED**

Patient Name	Date of Birth	Last 4 Digits of Social Security Number
Address	City, State, Zip Code	Telephone Number

**Authorization:** By signing below, I hereby authorize Centura Health and its affiliated facilities, agents, contractors, providers or associates to interview and/or take photographs of me. I understand that the term photograph may include, but not be limited to, videotape, videodisc, digital image and any other mechanical means of recording or producing visual images (hereinafter referred to as photographs). I also understand the interview session may involve, but not be limited to, audio tape, or other recording device, written recording or other mechanical means or medium to preserve the discussions (hereinafter referred to as interview material).

I understand and agree that the photographs and/or interview material may also be used and/or disclosed for any and all other purposes deemed appropriate by Centura Health, and its affiliated facilities, agents, contractors, providers or associates. Such purposes may include, but not be limited to, education, treatment, internal marketing (for example, photo displays within the facility), public relations, advertising, communication materials, promotional and marketing publications (including postings on an organization’s website), and/or fundraising activities.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment in any health plan, or eligibility for benefits. I understand that I may revoke this authorization at any time in writing by contacting the designated Health Information Management department and completing a Revocation of Authorization form.

I agree to hold Centura Health, and its affiliates, agents, officers, contractors, providers, directors, and associates, or designated third parties who are involved in the production, duplication, publication or any other use and/or disclosure of the photographs, and/or interview material harmless for any damages incurred by such use and/or disclosure of the photographs and/or interview material. I also understand that the photographs and/or interview material used and/or disclosed pursuant to this authorization may be re-disclosed by a recipient and can no longer be protected by the aforementioned parties.

In addition, I waive all rights to or conditions on the use and/or disclosure of these photographs and/or interview material that I may have pursuant to this authorization and for the consideration provided, I further waive any claim for payment or royalties related to the production, duplication, publication or other specified use and/or disclosure of such by Centura Health and/or any affiliated facilities, or any other party involved in the specified use and/or disclosure, now or in the future.

**Expiration:** Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless specified here: \_\_\_\_\_ (insert date or check box below)

- When no further production, duplication, publication or reprint or any other use of the photographs and/or interview material is required by Centura Health or its affiliated facilities.

**Compensation (if applicable):** The participant will receive consideration in the amount of \$ \_\_\_\_\_. Participant’s initials: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
Patient (Parent or Legal Guardian)

Name of individual signing on behalf of patient: \_\_\_\_\_

Relationship (if other than patient): \_\_\_\_\_

<b>OFFICE USE ONLY</b>	
Name of individual who received request: _____	Date received: _____
Patient Medical Record #/Account #: _____ / _____	Completion date: _____

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