Policy and Procedure: *HIPAA/HITECH Compliance*
Topic: *Individual Authorization for Disclosure*

HIPAA Regulation:

- *Authorizations* § 164.508

Policy Purpose:

The purpose of this policy is to assure authorizations for use or disclosure of protected health information in accordance with the HIPAA requirements.

Policy Description:

It is the policy of Saratoga Bridges that a valid authorization will be obtained for all disclosures that are not for treatment, payment, or health care operations, to the individual or their personal representative, to persons involved with the individual's care, to business associates in their legitimate duties, or for public purposes. This authorization will include all the mandatory elements and any authorizations generated from outside will be reviewed by the Privacy Officer to verify that they are valid.

Policy Responsibilities:

Program Staff

1. Obtains blank Authorization for the Use or Disclosure of Protected Health Information form.
2. Confirms the identity of the person who will sign the authorization (if not known). (If the person who will sign the authorization is a personal representative, i.e., guardian, health care proxy, family member, advocates, etc., confirms his or her relationship to the individual.)
3. Completes all parts of the authorization form that need to be completed and obtains required signatures. Does not leave any line blank.
4. Provides a copy of the signed authorization to the individual or personal representative.
5. Files a copy of the signed authorization in the HIPAA section of the record.
6. Where feasible, seeks the individual's verbal agreement to release or disclose Protected Health Information (PHI) to a family member or friend involved in the individual's care **before each such disclosure**.
7. If the individual provides verbal agreement, documents this in the clinical record.
8. Records verbal agreement in the HIPAA section. Includes the date, time, name, and telephone number of the family member or friend in the record, as appropriate. Staff member must sign and date the entry.

9. Does not discuss or disclose any information pertaining to the individual to any person who has not been granted specific, documented permission.
10. If the Authorization for the Use or Disclosure of Protected Health Information form was created by an outside provider or agency, forward the Authorization Form to the Privacy Officer/designee for review.

Privacy Officer

1. Reviews the Authorization for the Use or Disclosure of Protected Health Information form to assure the following information is present:
    a. A description of the information to be used or disclosed.
    b. The person(s) authorized to make the requested use or disclosure.
    c. The person(s) to whom the disclosure will be made.
    d. The purpose of the disclosure (Note: “At the request of the individual” is permissible).
    e. An expiration date or event.
    f. A statement of the individual’s right to revoke the authorization.
    g. Dated signature of the individual (if signed by a personal representative, a description of the representative’s authority to act for the individual should be included).
    h. A statement that authorization is not a condition of treatment, payment, or eligibility for benefits.
    i. A statement that information disclosed pursuant to the authorization may be further re-disclosed and no longer protected by HIPAA.

Appendix: Authorization for the Use or Disclosure of Protected Health Information Form

Authorization for the Use or Disclosure of Protected Health Information

Saratoga Bridges
16 Saratoga Bridges Blvd, Ballston Spa, NY 12020
Privacy Officer: Julianne Furlong Phone: (518) 871-9483

As required by the Health Insurance Portability and Accountability Act, Saratoga Bridges may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the <use / disclosure / use and disclosure> of the following health information that pertains to me:

_____

_____

for the following purpose:

_____

_____

I authorize the following persons to make these disclosures of my health information:

_____

_____

I authorize the following persons to receive these disclosures of my health information:

_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and will no longer be protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Organization. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire on: _____
(*must include a date or event).*

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain services will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

Print Name: _____

_____ _____
Signature Date

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____
Signature Date