

Tulane University

DEPARTMENT: General Counsel's Office – HIPAA	POLICY DESCRIPTION: Authorization for Release of Protected Health Information
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APPROVED: April 1, 2004	REVISED: August 6, 2004, December 1, 2008; March 24, 2009, August 3, 2010
EFFECTIVE DATE: April 14, 2003	POLICY NUMBER: GC-010

Tulane University Authorization for Release of Protected Health Information and Revoke Authorization

SCOPE OF POLICY

This policy applies to Tulane University Medical Group, its participating physicians and clinicians, and all University employees and business units who provide management, administrative, financial, legal, and operational support to or on behalf of Tulane University Medical Group and have been designated as part of the Tulane University HIPAA Health Care Component.

STATEMENT OF POLICY

The Tulane University Health Care Component must obtain a written authorization from a patient prior to using or disclosing of protected health information (PHI) for the purposes described in the implementation section of this policy and in the Tulane University Notice of Privacy Practices (the "Notice") or any joint notice with respect to organized healthcare arrangements in which Tulane University Medical Group participates ("Joint Notice"). Requests by Tulane University Medical Group patients relating to information maintained by a hospital should be referred to the hospital.

IMPLEMENTATION OF POLICY

Authorization for uses and disclosures of protected health information (PHI) must be obtained for:

- 1) Uses and disclosures outside of treatment, payment, and health care operations, unless otherwise permitted by law or the Notice or Joint Notice as applicable;
- 2) Uses and disclosures created for research (when required pursuant to policy GC-012);
- 3) Psychotherapy notes except:
 - a) To carry out treatment, payment, or health care operations:
 - i) Use by the originator of the notes for treatment;
 - ii) Use or disclosure in training programs in which trainees, students, or practitioner in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or
 - iii) Use or disclosure by a facility to defend a legal action or other proceeding brought on by the individual.
 - b) Use and disclosure with respect to oversight of the originator of the notes.

"Psychotherapy notes" means: notes recorded (in any medium) by a physician or clinician who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results

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of clinical tests, and any summary of the following items; diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.

Other authorization or consent requirements may apply, in accordance with the policy on *Sensitive Information*, GC-023, or *Billing Audits*, GC-024.

The provision of treatment to an individual may not be conditioned on signing an authorization except for:

- 1) Research-related treatment; and
- 2) Health care that is solely for the purpose of creating information for disclosure to a third party.

An individual may revoke an authorization in writing (see Attachment D) except to the extent that:

- 1) The facility has taken action in reliance thereon; or
- 2) If an authorization was obtained as a condition of obtaining insurance coverage.

PROCEDURE:

- 1) In general, all written authorization must be obtained using the authorization forms in this policy (see Attachment A, Attachment B, or Attachment C). However, any signed form presented by a patient or his/her representative that contains the same information as the form in Attachment A, B, or C is acceptable.
- 2) Every signed authorization must be documented and retained for a minimum of six (6) years.
- 3) An authorization for use of PHI may not be combined with any other document to create a compound authorization, except as follows:
 - a) An authorization for the use and disclosure of PHI created for research may be combined with any other type of written permission for the same research study, including another authorization or a research informed consent.
 - b) An authorization for use or disclosure of psychotherapy notes may only be combined with authorization for use or disclosure of psychotherapy notes.
 - c) An authorization in accordance with this policy, other than an authorization for a use or disclosure of psychotherapy notes, may be combined with any other authorization except when the provision of treatment or payment has been conditioned on the provision of one of the authorizations.

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Attachment A

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Attachment B

TULANE UNIVERSITY MEDICAL GROUP

HIPAA AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING, PUBLIC RELATIONS AND EXTERNAL COMMUNICATIONS

I authorize **Tulane University Medical Group** to use and/or disclose health information about

(Patient's Name)

for promotional, educational and informational purposes to local, state and national government officials; reporters for local, state and national media publications, including newspapers, magazines and on-line media; and to reporters for local, state and national television broadcast stations, or as otherwise specifically described:

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information:

____ Appearance/interview by media on camera; still photos or video footage for use in publications (print or electronic), web sites, audio, video, television commercial, advertising or film.

____ Other health information to be used or disclosed: _____

I understand that :

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation. Further details may be found in the Tulane University Medical Group Notice of Privacy Practices.
4. If the receiver is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may have a copy of this form after I sign it.

This authorization will expire one year after the date below, or sooner by my choice (in which case this consent will expire on _____).

SIGNATURES

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:

Date:

Print Name of Patient's Representative:

Relationship to Patient:

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Attachment C

INDIVIDUAL AUTHORIZATION

Patient Name: _____ ID Number: _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information may be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

A representative of Tulane University Medical Group must answer these questions completely before providing this authorization form to you. **Do not sign a blank form.** You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? The person(s) or class of persons authorized to disclose the information are described below.

Who will use and/or receive the information? The person(s) or class of persons authorized to receive the information are described below.

What information will be used or disclosed? The descriptions below should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed.

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below. The words, "at the request of the individual," are a sufficient description of the purpose when a patient initiates the authorization and chooses not to provide any further explanation of the purpose.

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below.

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

You have a right to refuse to sign this authorization. Your healthcare, the payment for your health care, and your healthcare benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at anytime, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to the manager of the specific site where you have been seen.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accepted the above.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address: _____
_____ (daytime)
_____ (evening)

Telephone:

Email Address (optional):

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

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Attachment D

**REVOKE AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)**

Patient's Name:	Birth Date:	SS#:
Address:		Telephone #:

I hereby REVOKE authorization from

to release the health information of

to

that was granted for the purpose of

Type of access that was granted:

<input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Itemized bill <input type="checkbox"/> Other _____
--

(Date)
Patient)

(Signature of Patient/Guardian/Patient Representative)

(Relationship to

(Printed name)

*Revocation of authorization for release of information except to the extent the action has been taken in reliance upon it.