

UMass Memorial Medical Center

Policies/Procedures and/or Guidelines Manual

1128 Authorization to Disclose Protected Health Information

Effective Date: 2/20/03

I. PURPOSE

To ensure that the Authorization for the Disclosure of Protected Health Information (authorization) is:

- Accurately and thoroughly completed when required, and;
- In effect (not revoked) prior to releasing protected health information, and;
- Filed in the patient's medical record in a timely manner.

II. SCOPE:

This policy applies to all members of the workforce who disclose protected health information regarding patients treated at UMass Memorial Medical Center (UMMMC), when the disclosure requires patient authorization. It also applies to Health Information Management staff that are responsible for filing the authorization forms.

III. DEFINITIONS:

- *Authorization* – a document signed and dated by the patient or authorized representative that permits release of specified protected health information to a specific person or entity for a specified purpose. A valid authorization includes an expiration date or event.
- *Authorized representative* – a Health Care Agent, Guardian or authorized next-of-kin. A Health Care Agent is an adult to whom authority to make health care decisions has been delegated under a Health Care Proxy in accordance with M.G. L. c. 201D. A guardian is an individual appointed by a court to make decisions on behalf of an incompetent person. In the absence of a Health Care Agent or Guardian, the statutorily established order of next-of-kin is as follows: spouse, children of legal age, parent(s), sibling(s) of legal age, grandparent(s) and aunt/uncle/first cousin of legal age.
- *De-Identified* – Health care information that is stripped of all identifying information and unique characteristics or codes including: Name; Address, including street address, city, county, zip code, or equivalent geocodes; Names of relatives and employers; Birth date; Telephone and fax numbers; E-mail addresses; Social security number; Medical record number; Health plan beneficiary number; Account number;

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Certificate/license number; Any vehicle or other device serial number; Web URL; Internet Protocol (IP) address; Finger or voice prints; Photographic images; and any other unique identifying number, characteristic, or code. Age and some geographic location information may be included in the de-identified information, but all dates directly related to the subject of the information must be removed or limited to the year, and zip codes must be removed or aggregated (in the form of most 3-digit zip codes) to include at least 20,000 people. Extreme ages of 90 and over must be aggregated to a category of 90+ to avoid identification of very old individuals. Other demographic information, such as gender, race, ethnicity, and marital status are not included in the list of identifiers that must be removed.

- *Demographics* – includes name, address, e-mail address, age but not birthdate, sex
- *Disclosure* – release, transfer, access to or provision of protected health information to the subject patient or third party outside of UMMMMC.
- *Fundraising* - organized activity of soliciting money or pledges for the benefit of UMMMMC.
- *Health Care Operations* – activities related to covered general administrative and business functions including quality improvement, care coordination, credentialing, training, accreditation, certification, licensing, insurance rating and other activities relating to the creation, renewal or replacement of a contract for health insurance or health benefits, conducting or arranging for medical review, legal or auditing services, business planning and development, general administrative functions such as fundraising (limited to demographics and dates of service), restructuring, grievance management, customer service including satisfaction surveys and activities to support an organized healthcare arrangement
- *Limited Data Set* - PHI that includes broad geographic information and dates (such as birth, death, admission, and discharge), but excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual: Names, Postal address information other than town or city, state, and zip code, Telephone numbers, Fax numbers, Electronic mail addresses, Social security numbers, Medical record numbers, Health plan beneficiary numbers, Account numbers, Certificate/license numbers, Vehicle identifiers and serial numbers, including license plate numbers, Device identifiers and serial numbers, Web Universal Resource Locators (URLs), Internet Protocol (IP) address numbers, Biometric identifiers, including finger and voice prints, Full face photographic images and any comparable images. A limited data set may be used or disclosed without authorization only for research, public health, or health care operations of another covered entity if it enters into a data use agreement with the limited data set recipient. The data use agreement provides assurance that the limited data set recipient will only use or disclose the PHI for limited purposes.
- *Marketing* – any communications about a product or service that is intended to encourage recipients of the communication to purchase or use the product or service. *The following activities are not considered marketing for purposes of this policy:*

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describing provider or plan network, describing covered or fee-for-service products/services of UMMMC, treatment communications (i.e. refill or appointment reminders even if provider is compensated by third party), case management or care coordination, and recommendation of alternative treatments, providers, or settings.

- *Payment* –activities undertaken by or on behalf of UMMMC to obtain reimbursement for the provision of health care. This includes coordination of benefits, billing, claims management, collections, medical necessity reviews, disclosures to consumer reporting agencies and utilization management.
- *Protected Health Information* –all individually identifiable health information created, transmitted, received or maintained by UMMMC. This includes any information, including demographics, which identifies or could reasonably identify an individual, their health/condition, treatment or provision/payment for their health care.
- *Statutorily Protected Medical Information* – records or information that is awarded special protection under federal or state law including, but not limited to information regarding psychiatric health, psychotherapy notes, alcohol and substance abuse treatment, domestic violence, sexual assault, sexually transmitted, AIDS/HIV, and abortion.
- *Treatment* – the provision of health care by, or the coordination or management of health care among, health care providers, or; the referral of a patient from one provider to another, or; the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.
- *UMMHC* – UMass Memorial Healthcare. Member organizations include the Medical Center (Hahnemann, Memorial and University campuses), UMass Memorial Home Health & Hospice, Clinton Hospital, Community Health Link, Health Alliance, Marlborough Hospital, UMass Memorial Medical Group, Wing Memorial Hospital & Medical Centers, Griswold Center, Quaboag Valley VNA & Hospice, and University Commons.
- *UMMMC* – UMass Memorial Medical Center Worcester campuses including University, Memorial and Hahnemann.

IV. RESPONSIBILITY:

All members of the workforce authorized to disclose protected health information are responsible for ensuring that the authorization is completely and accurately filled out when required, that the authorization has not been revoked, and that the most current authorization is referenced prior to disclosing the information. Those authorized to disclose protected health information may include, but is not limited to representatives from Health Information Management, Office of General Counsel, Central Business Office, Care Coordination, Compliance, Risk Management, Physicians, Emergency Department, Research, Information Services, Pharmacy, Clinics and Ancillary

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departments. The individual obtaining an authorization or revocation must ensure that the documents are properly filed in the patient's medical record.

V. POLICY STATEMENT:

Protected health information is confidential and can only be disclosed:

- With authorization from the patient or representative, or;
- For purposes related to treatment, payment, and healthcare operations of UMMMMC or;
- When required by law, or;
- When permitted under research provisions, or;
- When de-identified
- When data set is limited and used for research, public health, or healthcare operations and a data use agreement is in place.

Exception: An authorization is not normally required for purposes of treatment, unless the information is statutorily protected medical information. Authorization *is* required to disclose (outside UMMHC) statutorily protected medical information.

This policy is not meant to interfere with the normal flow of information between providers and patients. Providing the patient with a copy of lab results or other information for the patient to participate in his/her own treatment or discuss with another provider is considered treatment and does not require a signed authorization. Providers are encouraged to make note in the record of the information provided to patients.

VI. PROCEDURE:

A valid authorization is required to disclose protected health information to a patient or authorized representative, to third parties, for research when authorization is not waived by the Institutional Review Board, for marketing, and for fundraising when information other than dates of service and demographics is used.

1. Before disclosing protected health information for any of the above noted reasons, the person authorized to make the disclosure must verify that a valid authorization is in place. See attached "Authorization for the Disclosure of Protected Health Information" form. A valid authorization is legible, and includes the following elements:
 - **DESCRIPTION** - Specific description of the information to be used or disclosed. If an individual wishes to authorize a covered entity to disclose privileged information, or his or her entire medical record, the authorization can so specify.
 - **AUTHORIZED TO DISCLOSE** - Name or other specific identification of the person(s) or class of persons that are authorized to use or disclose the protected health information.
 - **AUTHORIZED RECEIVER** - Name or other specific identification of the person(s) or class of persons to whom the covered entity is authorized to make the use or disclosure.

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- **PURPOSE** - Identification for each purpose of the use or disclosure. It can be “at the request of the individual”.
 - **EXPIRATION DATE/EVENT** - This expiration date or event must be a specific date, a specific time period, or an event directly relevant to the individual or the purpose of the use or disclosure. It can be “none” or “end of study” for research authorizations only.
 - **SIGNATURE AND DATE**
 - **AUTHORITY TO REPRESENT** - If a personal representative of the individual signs the authorization, the representative must indicate his or her authority to act for the individual.
 - **RIGHT TO REVOKE** - Statement that the individual has the right to revoke the authorization in writing, except to the extent that action has been taken in reliance on the authorization or, if applicable, during when the law provides the insurer with the right to contest a claim under the individual’s policy.
 - **HOW TO REVOKE** - Instructions on how the individual may revoke the authorization or reference the Notice of Information if instructions are included there.
 - **NO CONDITIONING** - Statement that the covered entity will not condition treatment, payment, enrollment, or eligibility on the individual’s authorization for the use or disclosure (except when authorization is for clinical trial or the sole purpose of the authorization is to release information to a third party such as release of employment physical results).
 - **RE-DISCLOSURE** - Statement that information may be subject to re-disclosure by the recipient and may no longer be protected by this rule.
 - **REMUNERATION** - If the covered entity will receive remuneration from a third party in exchange for using or disclosing the protected health information (i.e. marketing), the authorization must include a statement that such remuneration will result.
2. The person authorized to make the disclosure must ensure that the authorization is currently in effect and has not been revoked. The request to revoke an authorization must be received in writing and signed/dated by the individual.
 3. The person authorized to make the disclosure must ensure that the valid authorization is filed in the patient’s medical record in a timely manner. The authorization must be retrievable upon request.

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NOTE: When requesting that another person or entity outside UMMMC disclose protected health information to UMMMC, the attached "Request for Disclosure of Protected Health Information" may be used. This form meets the requirements of the authorization form, and should therefore eliminate delays due to incomplete information. The workforce member making the request should request the minimal amount of information to accomplish the intended purpose of the request.

VIII. RESCISSION

This is a new policy.

Developed By: HIPAA Privacy & Security Committee

Anne Seger MD, Chairperson

Karen Nestor, Privacy Officer

508-334-8096

Individual/Committee

Extension

Approved By: John O'Brien
Authorized Signature

CEO
Title

2/20/03
Date



Authorization for the Disclosure of Protected Health Information

Please Print

Patient Name:	Date of Birth
Address	Social Security Number

I hereby authorize UMass Memorial Medical Center, a member of UMass Memorial Health Care, Inc. to disclose my protected health information to:

Name	
Address	
City, State, Zip	Telephone

I understand that my health information may include *general* information related to my psychiatric health, drug/alcohol abuse, communicable diseases, abortion, or other information I may consider sensitive.

I understand that this authorization pertains to information obtained on or before the date signed. I authorize the release of the following information for the period:

From _____ Through _____

General Records

- | | |
|--|---|
| <input type="checkbox"/> Cardiac Studies (Heart) | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Office/Clinic Notes for Dr. _____ |
| <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Operative/Procedure Reports |
| <input type="checkbox"/> EEG/EMG/Sleep Studies | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Emergency Service Records | <input type="checkbox"/> Problem List |
| <input type="checkbox"/> Home Health Records | <input type="checkbox"/> Pulmonary Studies (Lung/Respiratory) |
| <input type="checkbox"/> Hospice Records | <input type="checkbox"/> Radiology (X-ray/CAT/MRI/Ultrasound/Nuclear) |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Rehabilitation Notes (PT/OT/Speech) |

Statutorily Protected Records

- | | |
|--|--|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Domestic Violence Counseling |
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> HIV / AIDS Test Results / Treatment |
| <input type="checkbox"/> Psychiatric Health | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Sexual Assault Counseling | |

Other (specify) _____

The purpose of the release of this information is for:

- | | |
|--|--|
| <input type="checkbox"/> Continuing Medical Care | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Pre-employment | <input type="checkbox"/> Disability/Insurance Application or Claim |
| <input type="checkbox"/> Attorney / Legal Case | <input type="checkbox"/> Other (specify) _____ |

Additional Instructions: _____

Continued on Reverse

**Authorization for Disclosure
Of Protected Health Information**

RE: _____
Continued – Page 2

I understand that:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).
- I may inspect or copy information to be disclosed as provided in the Notice of Information. I understand that arrangements can be made to inspect my medical or billing record on-site, by contacting the Health Information Management department at the address noted below.
- There may be a fee for photocopying my health information.
- Any disclosure carries the potential for unauthorized re-disclosure. I release (insert member hospital) from any legal liability that may arise from the disclosure or re-disclosure of this information.
- I have the right to revoke the authorization at any time by presenting a written request to the Health Information Management Department (Medical Records) at the address below. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Expiration of Authorization: Unless otherwise revoked this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

Signature of Patient / Parent / Legal Representative	Date	Relationship to Patient
Witness to Signature	Date	Identification (for UMMMC use only) <ul style="list-style-type: none"> ▪ MA License ▪ Other

Please mail your request to:

Health Information Management – Room HB 354
UMass Memorial Medical Center
55 Lake Avenue North
Worcester, MA 01655



Request for the Disclosure of Protected Health Information

Please Print

To: _____

We understand that the following patient has received treatment from you. This individual is currently being treated at our facility, and we would appreciate a copy of the patient's protected health information as authorized by the patient below:

Patient Name:	Date of Birth
Address	Social Security Number

I hereby authorize the person/entity identified below to disclose my protected health information to UMass Memorial Medical Center, a member of UMass Memorial Health Care, Inc.

Name
Address
City, State, Zip

I understand that my health information may include *general* information related to my psychiatric health, drug/alcohol abuse, communicable diseases, abortion, or other information I may consider sensitive.

I understand that this authorization pertains to information obtained on or before the date signed. I authorize the release of the following information for the period:

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Statutorily Protected Records

- | | |
|--|--|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Domestic Violence Counseling |
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> HIV / AIDS Test Results / Treatment |
| <input type="checkbox"/> Psychiatric Health | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Sexual Assault Counseling | |

Other (specify) _____

The purpose of the release of this information is for: Continuing Medical Care

Continued on Reverse

Request for Disclosure Of Protected Health Information

RE: _____
Continued – Page 2

I understand that:

- This authorization is voluntary. I do not have to sign to assure treatment.
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