WEBER HUMAN SERVICES	**Policy & Procedure** HIPAA / PRIVACY **AUTHORIZATION FOR RELEASE OF PHI**	**NUMBER** 02 **APPROVED** 2/21/2014 **REVIEWED** 5/11/2017 **REVISED**

PURPOSE:

The purpose of this Policy is to set forth the Facility's process for the use and disclosure of Protected Health Information ("PHI") pursuant to a written authorization.

POLICY:

In accordance with the HIPAA Privacy Rule, when PHI is to be used or disclosed for purposes other than treatment, payment, or health care operations, the Facility will use and disclose it only pursuant to a valid, written authorization, unless such use or disclosure is otherwise permitted or required by law. Use or disclosure pursuant to an authorization will be consistent with the terms of such authorization.

PROCEDURE:

Exceptions to Authorization Requirements

PHI may be disclosed without an authorization if the disclosure is:

1. Requested by the client or his personal representative (authorization is never required);
2. For Internal program communications;
3. For the purpose of treatment, other than treatment for a substance use disorder;
4. For the purpose of the Facility's payment activities not related to SA treatment, or the payment activities of the entity receiving the PHI;
5. For the purpose of the Facility's health care operations;
6. In limited circumstances, for the health care operations of another Covered Entity, if the other Covered Entity has or had a relationship with the client;
7. To the Secretary of the U.S. Department of Health and Human Services for the purpose of determining compliance with the HIPAA Privacy Rule; or
8. Required by other state or federal law. (See "Request and Disclosure Table" in the "Uses and Disclosures of Protected Health Information" Policy for other exceptions.)

Use or Disclosure Pursuant to an Authorization

1. When the Facility receives a request for disclosure of PHI, the Privacy Officer, or designee shall determine whether an authorization is required prior to disclosing the PHI.
2. PHI may never be used or disclosed in the absence of a valid written authorization if the use or disclosure is:
    a. Of psychotherapy notes as defined by the HIPAA Privacy Rule;
    b. For the purpose of marketing; or
    c. For the purpose of fundraising.
3. If the use or disclosure requires a written authorization, the Facility shall not use or disclose the PHI unless the request for disclosure is accompanied by a valid authorization.

4. If the request for disclosure is not accompanied by a written authorization, the Privacy Officer shall notify the requestor that it is unable to provide the PHI requested. The Privacy Officer will supply the requestor with an Authorization form. (See sample Authorization form following this policy)
5. If the request for disclosure is accompanied by a written authorization, the Privacy Officer or other designee will review the authorization to assure that it is valid (see the "Checklist for Valid Authorization" following this Policy).
6. If the authorization is lacking a required element or does not otherwise satisfy the HIPAA requirements, the Privacy Officer will notify the requestor, in writing, of the deficiencies in the authorization. No PHI specified in the authorization will be disclosed.
7. If the authorization is valid, the Privacy Officer will disclose the requested PHI to the requester. Only the PHI specified in the authorization will be disclosed.
8. Each authorization shall be filed in the client's Medical Record.

Preparing an Authorization for Use or Disclosure

1. When the Facility is using or disclosing PHI and an authorization is required for the use or disclosure, the Facility will not use or disclose the PHI without a valid written authorization from the client or the client's personal representative.
2. The Authorization form must be fully completed, signed and date by the client or the client's personal representative before the PHI is used or disclosed.
3. The Facility may not condition the provision of treatment on the receipt of an authorization except in the following limited circumstances
    a. The provision of research-related treatment; or
    b. The provision of health care that is solely for the purpose of creating PHI for disclosure to a third party (i.e., performing an independent medical examination at the request of an insurer or other third party).
4. Mental Health Records require the approval of the mental health provider or their designee when requested by the client. If in the opinion of the provider it is felt that the information may be harmful to the client or others, the provider may deny access to the information. The client must be notified in writing if access is denied. Notify the Privacy Officer if access to medical records will be denied.

Revocation of Authorization

1. The client may revoke his authorization at any time.
2. Upon receipt of a written or oral revocation, the Privacy Officer or designee will revoke an electronically created disclosure by selecting "Revoke" in the disclosure tool, which marks the disclosure as "Revoked" in the list of disclosures and also places the watermark "Revoked" on the actual document. If the disclosure was completed on paper and was scanned into the EHR, the scanned document will be edited to include the "Revoked" watermark.
3. Upon receipt of a written or oral revocation, the Facility may no longer use or disclose a client's PHI pursuant to the authorization.

SAMPLE

Authorization
For Weber Human Services to Release Protected Health Information

Client Name	WHS#	
Former Names		
Birth Date		
Address		
City	State	Zip

I am requesting the following:	Release Records

The reason the information will be used or disclosed:

I authorize Weber Human Services and the person or entity listed below to use and/or disclose my medical, mental health, and/or substance abuse treatment records:		
Person/Entity		
Entity Address		
Entity City	Entity State	Entity Zip
Entity Phone	Entity Fax	

Weber Human Services Contact Information		
Program Name **Records Department**		
Contact Address **237 26th St.**		
Contact City **Ogden**	Contact State **UT**	Contact Zip **84401**
Contact Phone **(801) 625-3831**	Contact Fax **(801) 778-6803**	

I am authorizing the following information for use and/or disclosure:
☐ Evaluations ☐ Medication History ☐ Discharge ☐ Drug Testing Results ☐ Diagnosis ☐ Tx/Care Plan ☐ Treatment Compliance Reports ☐ Admission ☐ Other Information (explain)
Date Range Begin Date — Date Range End Date (optional)

By signing this form I understand the following:

- I may revoke this authorization at any time, except to the extent that action has already been taken. In the event I am court ordered to treatment, I understand revocation may put me in violation of the court order. To revoke this authorization, I must notify the Records Department in writing using the contact information above. Authorizations related to substance abuse records may be revoked verbally or in writing.
- There is the potential for re-disclosure of my mental health records by the receiver, and this re-disclosure may no longer be protected by federal or state law. Because of additional federal privacy rules (42 CFR Part 2), Substance abuse treatment records are prohibited from being re-disclosed without my written consent, unless permitted by federal or state law.
- I can request a copy of my record and/or inspect my record with my therapist. A supervisor will review and approve this request. I will receive an answer to my request within 60 days. My request may be denied if the supervisor of my case believes that access to my information could be harmful to me. If my request is denied I will be informed in writing.
- If this disclosure is set to expire based on an event, it is my responsibility to notify Weber Human Services when this event occurs.
- Signing this form is voluntary. It is not required to assure treatment with Weber Human Services. The parent/guardian and the minor must both sign to release substance abuse treatment records of a minor.

Expiration Date (if left blank, expires one year from today's date unless revoked)
Expiration Event

Client Signature	Client Signature Date
If Minor, Authorized Representative Signature	If Minor, Authorized Representative Signature Date
Printed Name of Authorized Representative	Relationship
Witness Signature	Witness Signature Date

CHECKLIST FOR VALID AUTHORIZATION

When you receive a request for release of Medical Records containing PHI from any entity other than the client or the client's personal representative, and the disclosure is not for purposes of treatment, payment or health care operations or another disclosure required or permitted by the HIPAA Privacy Rule, you may not release those records unless the requestor has provided a valid authorization. Use this checklist to assure that the authorization is valid. **If any one element is missing, the Privacy Rule prohibits you from disclosing the information.** You should contact the requestor and explain why you cannot disclose the information.

_____ The authorization must be written in plain language

All of the following elements must be included in the authorization:

_____ A specific and meaningful description of the information to be disclosed.

_____ The name or other specific identification of the person (or organization or class of persons) authorized to make the requested disclosure.

_____ The name or other specific identification of the person (or organization or class of person) to whom the information will be disclosed.

_____ The purpose of the requested disclosure. (If the client initiates the authorization, the statement "at the request of the client" is sufficient description of the purpose).

_____ An expiration date or an expiration event that relates to the client or the purpose of the disclosure.

_____ Signature of the client or personal representative and date.

_____ If signed by personal representative, a description of the representative's authority to act for the client.

All of the following elements must be included in the authorization related to Substance Abuse Treatment:

- How much and what kind of information is to be disclosed.

Required Statements:

_____ A statement that information disclosed pursuant to the authorization may be subject to redisclosure and may no longer be protected by the Privacy Rule.

_____ A statement of the client's right to revoke the authorization and either,

_____ A reference to the revocation right and procedures described in the Notice of Privacy Practices;

OR

_____ A statement about the exceptions to the right to revoke and a description of how the client may revoke.

_____ One of the following statements, or a substantially similar statement:

- If the Covered Entity is not permitted to condition treatment or payment on the provision of an authorization: I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

OR

- If the Covered Entity is permitted to condition the provision of research-related treatment on the provision of an authorization: I understand that the Facility will not provide research-related treatment to me unless I provide this authorization.

OR

- If the Covered Entity is permitted to condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party on the provision of an authorization: I understand that the Facility will not provide health care that is solely for the purpose of creating PHI for disclosure to a *third* party to me as unless I provide this authorization.

Defective Authorizations

If an authorization has any one of the following defects, it is invalid and any use or disclosure made pursuant to the authorization will be in violation of the Privacy Rule:

_____ The authorization has expired.

_____ One of the required elements or statements is missing.

_____ The Facility has knowledge that the authorization has been revoked.

_____ The authorization violates the regulations governing conditioning treatment or payment upon signing the authorization, or combining authorizations.

_____ The Facility has knowledge that information in the authorizations is false.