UC Riverside, School of Medicine Policies and Procedures
Policy Title: Authorization for Disclosure of PHI
Policy Number: COM 24.0

<table>
<thead>
<tr>
<th>Responsible Officer:</th>
<th>Compliance Officer</th>
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<tbody>
<tr>
<td>Responsible Office:</td>
<td>Compliance</td>
</tr>
<tr>
<td>Origination Date:</td>
<td>07/2013</td>
</tr>
<tr>
<td>Date of Revision:</td>
<td>N/A</td>
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Scope: To provide direction on those uses and disclosures of protected health information that requires valid patient authorization, and the requirements for a valid authorization.

I. Policy Summary:
The Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164), of the Health Insurance Portability and Accountability Act (HIPAA) provides federal protection for the privacy of health information. The Confidentiality of Medical Information Act, State law in California, also provides patient privacy protection. Federal HIPAA regulations require providers to conform to whichever federal or state law provides patients with greater protection or provides the patient with more rights over their information.

II. Definitions:
Operations - Certain administrative, financial, legal and quality improvement activities that are necessary to run business and to support the core functions of treatment and payment; includes case management and care coordination, evaluating provider performance, training health care and non-health care professionals, accreditation or licensing activities, medical review, legal and auditing services, business planning, customer service, and fundraising for the benefit of the covered entity.

Payment - Encompasses the various activities of health care providers to obtain payment or be reimbursed for their services; includes, but is not limited to: determining eligibility or coverage under a plan and adjudicating claims, risk adjustments, billing and collection activities, medical necessity/coverage determination, utilization review activities.

Protected Health Information (PHI) - An individual's health information, maintained in any form or medium, that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to the individual, or the past, present of future payment for the provision of health care to the individual; identifies the individual or is reasonably believed could identify the individual.

Treatment - The provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the
referral of a patient from one health care provider to another.

III. Policy:
All disclosures of protected health information that are not expressly permitted or required by law must be authorized in writing by the patient or the patient's legal representative. Please refer to UCR Health Policies "Access, Use and Disclosure of PHI" and "Mandatory and Required Disclosures of PHI."

The patient must authorize the disclosure in writing on a UCR Health Authorization for Release of Health Information form, or an external form that meets all of the requirements for a valid authorization. The Authorization form must meet the requirements of both HIPAA and California law.

Authorization is required for disclosure of:

- Any protected health information to a third party for which there is no permitted or required purpose for the disclosure.

- Psychotherapy Notes - A valid UCR Health Authorization for Release of Health Information form is required for disclosure of Psychotherapy Notes including for treatment, payment and healthcare operations except in the following situations:
  - Use by the originator of the notes for treatment
  - Use or disclosure by UCR Health of its own training programs in which students, trainees or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling
  - Use or disclosure by UCR Health to defend itself in a legal action or other proceeding brought by the individual
  - Use or disclosure that is required or permitted with respect to oversight of the originator of the notes

- For marketing using PHI, the Authorization for Release of Protected Health Information must state whether UCR Health receives any direct or indirect remuneration from the third party.

Authorization is not required for:
- communications that are face-to-face between UCR Health and the individual
- communications that describe UCR Health's own products or services to an individual; or
- promotional gifts from the UCR Health to the individual

- An IRB-approved research protocol that requires informed consent and the individual's Authorization for Release of Protected Health Information for
Research.

- Disclosure of PHI to the patient's employer (including those situations when the patient is a UC employee and the disclosure is to UC), except:
  - when the use and disclosure is for public health activities
  - to conduct an evaluation relating to medical surveillance of the workplace; or
  - to evaluate whether the individual has a work-related illness or injury

- Use of a list for fundraising activities that has been created using disease or treatment PHI or that clearly identifies an individual and his/her specific disease or treatment, or location of treatment.

- Use and disclosure of PHI to the media or through other forms of external communications.

- Creation of disease or treatment specific data bases (that have not been de-identified or are limited data sets) for purposes of institutional advancement or external communications activities.

- Use of disease or treatment specific data bases (that are not de-identified or limited data sets) created prior to April 2003 if those data bases were not created with specific legal permission from the individuals whose PHI is included in the data base.

- UCR Health may not disclose PHI to another covered entity without authorization or the use of a Limited or De-identified Data Set for the following operational activities of the other entity: resolution of internal grievances, customer service, medical review or auditing activities.

- UCR Health must obtain Authorization or use de-identified data when disclosing PHI to an Organ Procurement Organization (OPO) for purposes other than the purpose of facilitating organ, eye, tissue donation and transplantation.

- When PHI regarding an injured worker's previous condition is not directly related to the claims for compensation.

In all circumstances in which an authorization is required, disclosure of the following must be specifically authorized by the patient: HIV/AIDS test results, psychiatric, genetic test results, and drug/alcohol treatment information and genetic testing.

When another individual has authority to sign on an individual's behalf (personal representative), UCR Health staff must verify and document that person's authority to sign such legal permission, by making copies of any relevant
documentation granting such authority. A personal representative is someone who has the authority to act on behalf of an adult patient or emancipated minor patient in making decisions related to health care and the right to access or authorize use or disclosure of PHI. With respect to un-emancipated minors, the personal representative will generally be the parent.

A valid authorization must include:

- a description of the PHI to be used or disclosed
- the purpose of the disclosure
- the identity or class of individuals who are authorized to make the disclosure
- the name or class of persons to whom the information is to be disclosed, and
- the expiration date for the authorization

The authorization must be signed and dated by the patient, the patient’s legal representative, or the beneficiary or next of kin of a deceased patient. The State of California requires that the authorization form be in 14 point font.

The authorization must also include the following notifications to the individual:

- Instructions on how to revoke the Authorization in writing.

- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on the patient’s signing the Authorization.

- PHI may be re-disclosed by the person receiving the PHI, and in that case, the confidentiality of the PHI is no longer protected; and

- The patient, or the patient’s legal representative, has a right to receive a copy of the authorization form.

- When the Authorization is for marketing purposes, the Authorization must notify the individual of any direct or indirect remuneration to UCR Health from another party.

Authorizations submitted in person should be verified against the requestor's drivers' license to verify identify of the individual. For patient authorizations received through the mail/fax, staff must verify the identity of the patient by comparing the patient signature on the Authorization to patient signature in the medical record (for example, the Terms and Conditions form).

As a general rule, any requests for release of protected health information should be referred to University of California Riverside Health Correspondence, Health Information Management Department, 900 University Avenue, Riverside, California 92521.
IV. Responsibilities: N/A

V. Procedures:
   A. Health Information Management Staff

   1. Review the patient’s signed authorization to ensure that it is valid as defined above.
   2. Verify that the patient’s signature is valid and matches other signatures in the patient record.
   3. Verify the date of the authorization, and that the authorization has not expired.
   4. If the authorization is valid, follow normal procedure for processing the request.
   5. If the information is picked up by someone in person, the identification of the person receiving the information must be verified.

VI. Forms/Instructions: N/A

VII. Contacts:

<table>
<thead>
<tr>
<th>Unit</th>
<th>Title</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>Compliance and Privacy Officer</td>
<td>(951) 827-4672</td>
</tr>
<tr>
<td>Compliance</td>
<td>Privacy Analyst</td>
<td>(951) 827-7672</td>
</tr>
</tbody>
</table>

VIII. Related Information:
45 CFR Section 164 (the Privacy Rule)
California Medical Information Action §56 et sequelae
Lanterman-Petris Short Act

IX. Frequently Asked Questions: N/A

X. Revision History: N/A

Approval(s)

James R. Herron
Compliance and Privacy Officer
School of Medicine
Attachment A

Patient Name: ____________________________
Date of Birth: ____________________________
Patient Address: __________________________
City ____________________________ State ______ Zip Code ______
Phone Number: __________________________

I authorize UCR Health to release health information to:

Name of person or facility to receive health information

Specify name/title of person to receive health information, if known

Street Address, City, State, Zip Code

Phone number

INFORMATION TO BE RELEASED

☐ Discharge Summary ☐ Laboratory Reports ☐ Emergency Medicine Reports
☐ Billing Statements ☐ Dental Records ☐ History & Physical Exams
☐ Pathology Reports ☐ Operative Reports ☐ Diagnostic Imaging Reports
☐ EKG ☐ Other
☐ Progress Notes ☐ Radiology Reports ☐ Consultations
☐ Vaccinations/Immunizations ☐ Outpatient Clinic Records

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, et. seq.)
☐ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code §120980(g)).
☐ I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j)).
Nombre del Paciente: ____________________________________________
Fecha de Nacimiento: ____________________________________________
Dirección del Paciente: ____________________________________________

Ciudad  Estado  Código Postal
Número de Teléfono: ____________________________________________

Autorizo al UCR Health para proporcionar/entregar información sobre la salud a:

Nombre de la persona o institución que recibirá la información sobre la salud

Especificar nombre/título de la persona que recibirá la información sobre la salud, si se conoce

Dirección (Calle, ciudad, estado, código postal)

Número de teléfono ________________

<table>
<thead>
<tr>
<th>INFORMACIÓN A SER ENVIADA</th>
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<tbody>
<tr>
<td>☐ Resumen de alta</td>
</tr>
<tr>
<td>☐ Detalle de facturación</td>
</tr>
<tr>
<td>☐ Informes de patología</td>
</tr>
<tr>
<td>☐ Electrocardiograma</td>
</tr>
<tr>
<td>☐ Notas sobre evolución clínica</td>
</tr>
<tr>
<td>☐ Vacunas/Immunizaciones</td>
</tr>
<tr>
<td>☐ Otros</td>
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ESPECIFIQUE LA FECHA O PERÍODO DE TIEMPO PARA LA INFORMACIÓN SELECCIONADA ARriba

<table>
<thead>
<tr>
<th>AUTORIZACIONES ESPECÍFICAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Autorizo específicamente la entrega de la información correspondiente al diagnóstico o tratamiento de abuso de drogas y alcohol (42 C.F.R. §§2.34 y 2.35).</td>
</tr>
<tr>
<td>☐ Autorizo específicamente a entregar información correspondiente al diagnóstico o tratamiento de la salud mental (Welfare and Institutions Code §§5328, et seq.)</td>
</tr>
<tr>
<td>☐ Autorizo específicamente la entrega de información sobre las pruebas de VIH/SIDA (Health and Safety Code §120980[g]).</td>
</tr>
<tr>
<td>☐ Autorizo específicamente la divulgación de información sobre pruebas genéticas (Health and Safety Code 124980[i]).</td>
</tr>
</tbody>
</table>
THE PURPOSE OF THIS RELEASE IS (check one or more)

☐ Continuity of care or discharge planning
☐ Billing and payment of bill
☐ At the request of the patient/patient representative
☐ Other (state reason) ______________________________

NOTICE
UCRH and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS
☐ I understand this authorization is voluntary. Treatment, payment enrollment or eligibility benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
☐ I may revoke this authorization at any time, provided that I do so in writing and submit it to UCR Health, School of Medicine, 900 University Avenue, Riverside, CA 92521. The revocation will take effect when UCRH receives it, except to the extent that UCRH or others have already relied on it.
☐ I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this authorization expires ________________ (insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form.

PERSONAL USE
I understand I will be charged a per page fee for copies produced for my personal use.

Initial ________________

SIGNATURE

(Signature of Patient or Patient's Legal Representative) ______________________________

Date: __________________

Time: _______ AM/PM

Printed Name ________________

(If signed by someone other than the patient, state your legal Relationship to the patient/authority)

Mail form with original signature to:
UCR Health
School of Medicine
900 University Avenue
Riverside, CA 92521
1-855-827-CLINIC (2546)

Witness or Translator ______________________________
EL PROPÓSITO DE LA ENTrega DEL expediente MÉDICO

☐ Continuidad de la atención médica o planificación de dada de alta
☐ Facturación y pago de los servicios
☐ Ante la solicitud del paciente/representante del paciente
☐ Otros (declare la razón) _______________________________________________________________________

AVIS0
El UCRH y muchas otras organizaciones y personas tales como médicos, hospitales y planes de atención médica tienen el mandato legal de mantener su información médica bajo confidencialidad. Si usted ha autorizado la entrega de su información sobre la salud a alguien que no está legalmente obligado a mantenerla bajo confidencialidad, la misma ya no estará resguardada por las leyes federales y estatales de confidencialidad.

MIS DERECHOS
☐ Comprendo que esta autorización es voluntaria. El tratamiento, el pago por inscripción y la elegibilidad para recibir beneficios no se puede condicionar a la firma de esta autorización excepto que la misma esté destinada a: 1) realizar un tratamiento vinculado con una investigación, 2) obtener información relacionada con la elegibilidad o inscripción a un plan de atención médica, 3) determinar la obligación de una entidad de pagar una demanda, o 4) generar información sobre la salud para suministrarla a una tercera parte. Sin embargo, bajo ninguna circunstancia se me solicita autorizar la entrega de expedientes sobre la salud mental.

☐ Puedo revocar esta autorización en cualquier momento, bajo condición de realizarlo por escrito y presentarlo ante UCR Health, School of Medicine, 900 University Avenue, Riverside, CA 92521. La revocación entrará en vigor cuando UCRH la reciba, excepto en la medida que UCRH u otros ya se hayan sujetado a la misma.

☐ Tengo derecho a recibir una copia de esta Autorización.

VENCIMIENTO DE LA AUTORIZACIÓN
A menos que se la revoque en otras circunstancias, esta autorización vence ____________ (completar con la fecha o hecho pertinente). En caso de no indicarse una fecha, esta autorización vencerá a los 12 meses de la firma del presente formulario.

USO PERSONAL
Entiendo que se me cobrará una tarifa por página por cada copia que solicite para mi uso personal.

Inicial ______________________________________

FIRMA

(Firma del Paciente o Representante Legal del paciente) ____________________________________________

Fecha: ____________________

Hora: _______ AM / PM

Nombre en Letra de Molde ________________________________________________________________

(Si la firma no corresponde al paciente, declare su relación legal con el paciente/autorización)

Testigo o traductor ______________________________________________________________________