ORGANIZATION POLICY

POLICY TITLE: ONSLOW MEMORIAL HOSPITAL USE OF OMH CORPORATE AUTHORIZATION FORM

POLICY NUMBER: 1304

(1) **AUTHORITY**: This Policy is enacted pursuant to authority delegated to the management of Onslow Memorial Hospital, Inc. ("OMH") by its board of directors.

(2) **APPLICABILITY**: This Policy shall apply to all employees and agents of the Hospital. This Policy shall become effective when approved and signed by the President and Chief Executive Officer of OMH.

(3) **PURPOSE AND APPLICABLE LAW**: The purpose of this Policy is to establish OMH's use of OMH corporate authorization form.

OMH may use and disclose protected health information without authorization for treatment, payment and healthcare operations. No OMH department shall otherwise use or disclose, or be required to use or disclose, protected health information about any such individual without that individual's explicit authorization, except for specifically enumerated purposes such as emergency treatment, public health, law enforcement, audit/oversight purposes, or unless state or federal law allows specific uses and disclosures.

OMH shall disclose protected health information only upon authorization by the patient or patient's authorized personal representative, unless state or federal law allows for specific exceptions. Authorizations obtained or received for disclosure of protected health information must be consistent with authorization requirements identified in this policy. An authorization permits, but does not require, OMH disclose protected health information.

Model Authorization

OMH shall utilize a model authorization form, *Authorization to Disclose Health Information* (see Attachment A), which contains the elements necessary to be considered a valid, HIPAA-compliant authorization. The standard authorization form must be written in plain and simple language that a patient or a patient's personal representative can easily read and understand.

Any alterations to the model authorization form must first be approved by OMH's Privacy Officer, who is responsible for the development and maintenance of the model authorization form.

Valid Authorization

The OMH model authorization form shall contain the core elements listed below.

- A specific and meaningful description of the information to be used or disclosed;
- The name or other specific identification of the person or class of persons authorized to make the requested use or disclosure of the information;
- The name or other specific identification of the person or class of persons to whom the use or disclosure can be made;
- A description of each purpose of the requested disclosure (the statement "at the request of the patient" is a sufficient description of the purpose when a patient initiates the authorization and does not, or elects not to, provide a statement of the purpose);
- An expiration date or event that relates to the patient or the purpose of the use or disclosure, for example "1/31/04" or "after the disclosure to my doctor"; and
- The signature of the patient or the patient's personal representatives and the date of the signature. If a patient's personal representative signs the authorization form, a description of the personal representative's authority to act on behalf of the patient must also be provided. Please refer to Medical Records Departmental Policy *Release of Medical Information* for further information on personal representatives.
- A specific statement about any confidential HIV-related information that will be disclosed.

In addition to the required elements, the authorization form must contain statements that inform the patient or the patient's personal representative of the following:

- The patient's right to revoke the authorization;
- The exceptions to the right to revoke;
- A description of how the patient may revoke the authorization;
- The consequences (as identified in the "Conditioning of Authorizations" section of this policy) to the patient for refusal to sign the authorization form; and
- The potential for information to be subject to re-disclosure by the recipient and no longer protected by state or federal law.

OMH must provide a copy of the signed authorization to the patient or the patient's personal representative upon request.

Third Party Authorization Forms

All third parties requesting a patient's protected health information from OMH must provide OMH with a valid HIPAA-compliant authorization form. Invalid forms will be returned to sender with OMH's *Authorization for Release of Health Information* for completion.

Invalid Authorization

An authorization shall be considered invalid if the document has any of the following deficiencies:

- The expiration date has passed or the expiration event is known to have occurred;
- The authorization form is not completely filled out;
- The authorization form does not contain the core elements of a valid authorization;
- The authorization is known to have been revoked;
- Any information recorded on the authorization form is known to be false; or
- An authorization for psychotherapy notes is combined with a request for disclosure of information other than psychotherapy notes.

Compound Authorization

An authorization for disclosure of protected health information shall not be combined with any other written legal permission from the patient or the patient's personal representative (e.g., Consent for Treatment, Assignment of Benefits).

An authorization that specifies a condition for the provision of treatment, payment, enrollment in a health plan or eligibility for benefits may not be combined with any other authorization.

Conditioning of Authorization

The provision of treatment, payment, and enrollment in a health plan or eligibility for benefits shall not be conditioned on whether or not a patient or a patient's personal representative signs an authorization form, except as follows:

- The provision of research-related treatment can be conditioned on authorization to use or disclose protected health information for such research;
- Provision of health care solely for the purpose of creating protected health information for disclosure to a third party (e.g., physical exam for life insurance).

Signatures

Each authorization must be signed and dated by the patient or the patient's personal representative. If a patient's personal representative signs the authorization form, a description of the personal representative's authority to act for the patient must also be documented on the form.

If a patient or a patient's personal representative is unable to sign his/her name, an "x" or other mark/symbol is acceptable in place of a signature, as long as it is witnessed and documented, attesting to the validity of the signature.

Dates

Each authorization must state an expiration date or event, such as a specific time (e.g., January 1, 2003); a specific time period (e.g., one year from the date of signature); or an event directly relevant to the client or the purpose of the disclosure (e.g., 60 days following discharge from OMH).

The expiration date or event for each authorization must be acknowledged and actions taken on that authorization must be consistent with such limitations. An authorization without an expiration date shall be considered invalid.

Revocation of Authorization

The authorization must state that a patient has the right to revoke the authorization at any time, except to the extent that OMH has already taken action based upon the authorization or the authorization was obtained as a condition for obtaining insurance coverage. The revocation must be in writing and signed by the patient using the *OMH Request to Revoke Authorization Form* (see Attachment B). Revocations shall become a permanent part of the patient's designated record set, and shall be maintained as per OMH Policy *Components of the Designated Record Set.*

Until a valid authorization has expired or is revoked, OMH may use or disclose protected health information created after the date the authorization was created. For example, if a patient requests all oncology records be sent to a lawyer on 01/01/04, the patient indicated and expiration date of 12/31/04 on the *Authorization for Release of Health Information* and the patient continues to see the oncologist until 03/04, the lawyer specified in the original authorization may have access to the newly created protected health information.

Photocopy/Facsimile Authorizations

An original authorization form is preferred for disclosure of protected health information; however, a clear and legible photocopy/facsimile is acceptable.

Documenting Authorizations

OMH must prepare and maintain current and accurate documentation of the following:

- Policies and procedures about preparing, obtaining, handling and retaining patient authorizations;
- Policies and procedures about the process used to satisfy a valid patient authorization;
- Signed authorizations and revocations, maintained in the patient's designated record set;
- The person(s) responsible for processing authorizations.

EFFECTIVE DATE: June 2005

REVISION DATE: January 16, 2006, January 12, 2009

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AUTHORIZATION FOR RELEASE OF HEALTH INORMATION

OMH and its business associates 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 will be used or disclosed. Please read the information below carefully before signing this form.

Section A: Release of Protected Health Information

Patient Information:	First	Middle	Last Any Former Name(s)
	Telephone Number	Social Security Number	Date of Birth
To Whom Medical Information May be Released:	Person or Organization (Please Include Address and Phone Number)		
Method of Disclosure:	❒ Pick Up ❒ Mail ❒ Fax to: _____ (Fax Number or Address)		
Specific Document(s) Needed:	❒ Abstract* ❒ Electrocardiogram ❒ Lab Report ❒ Photo, video, other image ❒ Clinic Note ❒ Emergency Dept. Record ❒ List of Disclosures ❒ Prenatal Record ❒ Consult ❒ History and Physical ❒ Operative Report ❒ Psych Record ❒ Discharge Summary ❒ HIV/AIDS (_____ initial) ❒ Pathology Report ❒ Radiology Report ❒ Other (please specify) _____		
Specific Department(s):	❒ Admissions ❒ Laboratory ❒ Radiology ❒ Cardiac Catheterization Lab ❒ Materials Management ❒ Respiratory Therapy ❒ Cardiac Rehabilitation ❒ Medical Records ❒ SurgiCare ❒ Cardiology ❒ Neurology ❒ Utilization Review ❒ Emergency Department / Intensive Care Unit ❒ Patient Financial Services ❒ Other_____ ❒ Physical / Occupational / Speech Therapy Rehabilitation ❒ Pharmacy		
Purpose:	❒ Continuity of Medical Care ❒ Insurance Processing ❒ Legal Proceedings ❒ At The Request of the Individual ❒ Other _____		
Period of Treatment:	From _____ To _____		
Expiration Date/Event of Authorization:	❒ 30 Days ❒ 60 Days ❒ 90 Days ❒ Other (explain):		

* An abstract may include the following: discharge summary, history & physical, consults, operative reports, pathology reports, laboratory reports, radiology reports, special tests, and Emergency Department records.

Section B: Specific Understanding	
1.	I, or my personal representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.
2.	I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.
3.	I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, OMH cannot honor my request to disclose my medical and/or billing information.
4.	I understand that if my medical and/or billing records contain information relating to **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check and initial the box on the front of this form.
5.	I understand that I have the right to request to inspect and/or receive a copy of the information described on this authorization form. I also understand that I have a right to receive a copy of this form after I have signed it.
6.	I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that the hospital has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage. To revoke this authorization, please put your request in writing and send to OMH Medical Records.

Patient Understanding and 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 accept all of the above.

Signature of Patient or Personal Representative	**Printed Name of Patient or Personal Representative**
Date	**Description of Personal Representative's Authority**

Office Use Only

Form of Identification:	❒ Drivers License	❒ State ID	❒ Military ID	❒ Other_____
Request Filled By:				
Notes:				

Last revised: 1/12/2009