SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Central Services Policies and Procedures

November 14, 2016

TO: SCVHHS Executive Management Group

FROM: René G. Santiago, Deputy County Executive, SCVHHS

SUBJECT: **Obtaining and Complying with Patient Authorization**

REFERENCE:
45 CFR § 164.508
42 CFR § 2.31(a)(8); § 2.13 and § 2.32
Civil Code Sections 56.11, 56.12, 56.37, and 56.15
Health & Safety Code Section 120980
Welfare and Institutions Code (WIC) Sections 5328 and 5328.7
HHS 585.19 Policy "Disclosure of Protected Information Without an Authorization"
HHS 585.03 Policy "Use and Disclosures of PHI for Research"
HHS 585.26 Policy "HIPAA Privacy Rule Definitions"
HHS 585.04 Policy "Verification of Identity and Authorization"
HHS 585.10 Policy "Processing Requests for Access to Protected Health Information"

DEFINITIONS

Refer to SCVHHS 585.26 Policy "HIPAA Privacy Rule Definitions."

BACKGROUND:

Santa Clara Valley Health & Hospital System (SCVHHS) collects and maintains protected health information (PHI)/electronic Protected Health Information (ePHI) about our patients and plan members. The federal HIPAA Privacy Rule requires that SCVHHS may not use or disclose PHI/ePHI without an authorization unless such use or disclosure is permitted or required by law.

POLICY:

SCVHHS will obtain a written authorization from the individual or the individual's representative to use and disclose the individual's protected health information, unless the use and disclosure is otherwise permitted or required by federal and/or state law.

This policy applies to all SCVHHS operations, including Behavioral Health, covered entity functions of the Public Health, Valley Health Plan, Custody Health, and Santa Clara Valley Medical Center.

PROCEDURE:

SCVHHS Workforce Members

Obtaining a HIPAA Authorization Form

1. Determine whether or not a HIPAA authorization is required. If needed, contact the Ethics & Compliance Office. Examples of specific disclosures which require authorization include:
    a. Request from an adult patient's friends or family members
    b. Camp or school physical forms (if such form will be released to anyone other than the parent)
    c. Immunization records (if such form will be released to anyone other than the parent)
2. Obtain a completed and signed "Attachment A: *SCVHHS Authorization for Use and/or Disclosure of Protected Health Information"* from the patient and/or patient's representative.
3. Upon receiving a completed and signed "Attachment A: *SCVHHS Authorization for Use and/or Disclosure of Protected Health Information,"* workforce members must collaborate with the applicable department's custodian of records below to review the authorization request.
    a. Valley Medical Center: Health Information Management Department, 408-885-5125
    b. Behavioral Health: Compliance Department, 408-885-5770 or 408-885-6041
    c. Valley Health Plan: Compliance Department, 408- 885-5780
    d. Custody Health: Health Information Management Department, 408-885-5125
    e. Public Health: Medical Admin Assistant 408-792-3798
4. Upon receiving a request or written authorization to disclose protected health information that is not on the "*SCVHHS Authorization for Use and/or Disclosure of Protected Health Information"* form, workforce members must collaborate with the applicable department's custodian of records to review the authorization request.

Review for a Valid HIPAA Authorization

SCVHHS Custodian of Medical Records or designee

1. Determine that the authorization form is valid before making any uses or disclosures of PHI/ePHI. Refer to Attachment C " *How to fill out SCVHHS Authorization for Use or Disclosure of Patient Health Information"* for further instructions
2. Valid authorization:
    a. Must be fully completed, signed and dated by the patient/ plan member or by the patient's/plan member's representative at the bottom of the form.
    b. Must be fully signed and dated by the patient/plan member or by the patient's/plan member's representative on appropriate fields for disclosure of (1) medical records or (2) HIV/AIDS test result, or (3) mental health

record, or (4) drugs and alcohol records.

c. Not be known to be inaccurate, or expired or revoked.
d. Must include a specific expiration date (*e.g.,* July 1, 2003) or a specific time period (*e.g.*, one year from the date of signature).

3. Verify the authority and identity of any patient's/plan member's representative that signs an authorization according to established policies and procedures.

SCVHHS Custodian of Medical Records or designee

Prepare for a Disclosure and/or Release of Medical Records

If applicable, Custodian of Medical Records or designee follows its internal procedures to disclose or release of medical records.

1. If the authorization is valid, the custodian of record will disclose the requested PHI to the requestor. Only the PHI specified in the authorization will be disclosed.
2. If the authorization is NOT valid, the custodian of record notifies the requestor if the authorization is lacking of required elements. No PHI will be disclosed unless and until a valid authorization is received.
3. For release of drugs and alcohol medical records pursuant to 42 C.F.R. Part 2, include Attachment C "*Notice Prohibiting Redisclosure Of Alcohol Or Drug Treatment Information"* to the recipients.
4. For release of mental health medical records that are protected by WIC Section 5328 (e.g Emergency Psychiatric Services (EPS), Barbara Arons Pavilion (BAP), Custody Health Mental Health Unit- 8A, Behavioral Health Services Department), the licensed clinician in charge of the patient is presumed to have approved a request for release by the patient unless otherwise indicated or flagged in the medical record by the licensed clinician.
    a. If the health care provider determines that there is a substantial risk of significant adverse or detrimental consequences to a patient in receiving a copy of mental health records, the provider must notify the custodian of medical record for denial of a copy of medical record.
    b. The custodian of medical record must follow HHS #585.10 policy or its internal procedures in responding to a denial of medical record request.
5. Each authorization will be filed in the patient's medical record.

Attachment A: *SCVHHS Authorization Form for Use and/or Disclosure of Protected Health Information*
Attachment B: *SCVHHS Clinic Location*
Attachment C: *How to fill out SCVHHS Authorization for Use or Disclosure of Patient Health Information*
Attachment D: *"Notice Prohibiting Redisclosure Of Alcohol Or Drug Treatment Information"*

Issue: 4/23/2003
Revised: 10/21/2009, 11/14/2016

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Department logo & contact can be inserted here. (VMC, PH, BH, Custody, VHP)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1

Patient Name:_____
Date of Birth:_____
ID or Medical Record #_____
Address:_____
City:_____
State:_____ Zip Code:_____
Tel:_____

2 AUTHORIZATION: I give permission to _____to use and release to
Recipient Name:_____
Address:_____
Phone:_____Fax:_____

3 PURPOSE: The health information disclosed may only be used for the following purpose(s):_____
_____
_____

4 INFORMATION TO BE RELEASED (Check the appropriate box)

A. MEDICAL
- ☐ All health information (e.g. diagnosis, test results, treatment); OR
- ☐ X-Ray ☐ Images and/or Films ☐ Reports ☐ Billing
- ☐ Only the following information_____
  - ➢ Clinic location can be selected from Attachment B_____ Dated from_____ to_____

B. HIV/AIDS TEST RESULTS (A separate authorization is required for each disclosure.) - Initials: _____

C. DRUGS & ALCOHOL TREATMENT - Initials:_____
- ☐ All drugs & alcohol information (e.g. diagnosis, test results, treatment, billing, attendance); OR
- ☐ Only the following information_____

D. MENTAL HEALTH - Initials:_____
- ☐ All mental health information (e.g. diagnosis, test results, treatment, billing); OR
- ☐ Only the following information_____
  - ➢ Clinic location can be selected from Attachment B_____Dated from_____ to_____

5 DELIVERY PREFERENCE:
☐ Mail ☐ Pick up ☐ Fax

6 DELIVERY FORMAT:
☐ CD ☐ Film ☐ Paper ☐ Verbal

7 DURATION: This authorization is valid immediately and will be valid until_____(*give date*). If I do not write in a date, it will expire twelve months from the date it was signed.

8 CANCELLATION: I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the Health Information Management Department, 751 S. Bascom Ave., San Jose, CA 95128 and 3) is effective when it is received by the department. A cancellation will not apply to actions already taken by SCVHHS under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim. Verbal cancellation will be accepted for behavioral health medical record pursuant to WIC Section 5328. Call: 408-885-5770.

9 CONDITIONS: I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.
A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

10

_____ _____ _____ _____
Patient/Patient's Representative Name Patient/Patient's Representative Signature Relationship Date

Department logo & contact can be inserted here. (VMC, PH, BH, Custody, VHP)

Attachment B: Santa Clara Valley Health & Hospital System Locations – To be updated and edited by the Department Custodian of Medical Record as applicable.

Valley Medical Center

- ☐ Valley Medical Center Hospital
- ☐ Valley Homeless Clinic
- ☐ Medical Respite Center
- ☐ Bill Wilson Drop-In Center Clinic
- ☐ Spark Clinic
- ☐ Valley Specialty Center
- ☐ Renal Care Center
- ☐ Valley Health Care Clinic - Milpitas
- ☐ Valley Health Care Clinic - Moorpark
- ☐ Valley Health Care Clinic - Sunnyvale
- ☐ Valley Health Care Clinic - Tully
- ☐ Valley Health Care Clinic - Downtown
- ☐ Valley Health Care Clinic - Milpitas
- ☐ Valley Health Care Clinic - Bascom
- ☐ Valley Health Care Clinic – East Valley
- ☐ Valley Health Care Clinic - Gilroy

Attachment C: How to fill out "Authorization for Use or Disclosure of Patient Health Information" form.

1 Requestor must complete this section. If not complete, form may be returned. Complete each box with the following information (print clearly):

- Patient's name.
- Patient's Date of Birth.
- ID or Medical Record Number.
- Home Address, including City, State and Zip Code.
- Telephone Number

2 Insert the department (VMC, VHP, Behavioral Health, Custody, or Public Health) under the "I give permission to" box. Then, write the name of the person or organization who is to receive the information.

- Name or Organization.
- Street Address, including City, State and Zip Code.
- Telephone/Fax Number of person who will receive information.

3 State the purpose for the release of information. Examples: Insurance application, Legal, Benefits, School, etc. ("For my own purposes" can only be used when releasing records to yourself).

4 Indicate what information may be released. Check the boxes that apply to your request and be specific:

- Specify type of information: medical records, HIV/AIDS test results, drug and alcohol treatment, and/or mental health records.
- Initial where indicated.
- If applicable, specify type of information such as x-ray, images, reports, or billing; or
- Specify clinic location where services were received. Refer to Attachment B for listed SCVHHS locations
- Specify date range of records being requested, if applicable.

5 Indicate how to receive the information: mail, pick up, or fax. If no method selected, default will be paper records for pick up.

6 Please indicate if you want paper, CD, films, or verbal release. If no method selected, default will be paper records for pick up.

7 List date authorization expires. If no date listed, authorization is valid for one (1) year.

8 Please read cancellation rights.

9 Please read conditions.

10 Print name, sign and date the authorization. Identify the relationship with the patient signs by patient's representative.

**There may be a fee associated with this request. Please contact the Custodian of Records to get a list of fees.

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Attachment D:
NOTICE PROHIBITING REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT INFORMATION

Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.