



Office of Regulatory Compliance

HIPAA Policy 3.1

Title:	Valid Authorization
Source:	Office of Regulatory Compliance
Prepared by:	Assistant Vice Chancellor for Regulatory Affairs
Approved by:	Vice Chancellor for Research
Effective Date:	July 1, 2013
Replaces:	02/26/03
Applies:	All UCD campuses

Introduction

Purpose

To ensure that all authorizations as required by HIPAA contain specified elements in order for them to be considered valid for the use or disclosure of Protected Health Information (PHI). UCD may not use or disclose PHI without a valid authorization from an individual or his or her representative, except as otherwise permitted or required and described within this policy or other UCD HIPAA policies. Use or disclosure of PHI must be consistent with what is included in the valid authorization and for the specified purpose.

Reference

45 C.F.R. § 164.508

Applicability

It is the responsibility of anyone who uses or discloses PHI to follow this policy and ensure that a valid authorization has been obtained, except as otherwise permitted or required by this policy or other UCD HIPAA policies, prior to the use or disclosure of PHI as described in the valid authorization.

This policy applies to obtaining a valid authorization for the use or disclosure of PHI, except as otherwise permitted or required by this policy or other UCD HIPAA policies.

Policy

The UCD has a standard format and guidelines for obtaining valid authorization for the use and disclosure of PHI. The UCD Authorization Form Template (attached) and Directions should be used to create all authorizations. If the template cannot be used, the following procedures must be followed. Exceptions to obtaining a written and valid authorization from the individual whose PHI is being used or disclosed are included in this and other UCD HIPAA policies.

Procedures

1. A valid authorization must contain the following elements:
 - a. Specific description of the information to be used or disclosed;
 - b. Name of person(s) or job title authorized to make the use or disclosure;
 - c. Name of person(s), business name, or class of persons to whom UCD can make the requested use or disclosure;
 - d. Description of each purpose of the requested use or disclosure;
 - e. Expiration date or expiration event; and,
 - f. Signature of the individual and date.

If the authorization is signed by a personal representative, a description of the representative's authority to act for the individual must also be provided.

2. A valid authorization must be written in plain language.
3. A valid authorization must contain statements adequate to place the individual on notice of all of the following:
 - a. The individual's right to revoke the authorization in writing and the exceptions to the right to revoke and a description of how the individual may revoke the authorization.
 - b. A statement that:
 - i. the UCD may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization, if the UCD may not condition the authorization pursuant to UCD HIPAA Policy 3.4; or,
 - ii. if the UCD may condition the authorization pursuant to UCD HIPAA Policy 3.4, the consequences to the individual of a refusal to sign the authorization; and,
 - c. A statement that the potential exists for information disclosed via the authorization to be subject to redisclosure by the recipient of the information and therefore no longer protected by HIPAA.

4. UCD must provide the individual with a copy of the signed and dated authorization.
5. UCD must retain the authorization for six years following the date it was signed or was last in effect, whichever is later.
6. An individual may revoke an authorization at any time, provided that the revocation is in writing, except to the extent that UCD has taken action based on the authorization and prior to notice of revocation. (See UCD HIPAA Policy 3.5.) If revoked, the authorization is not valid and may not be used.
7. The UCD may not use the authorization if:
 - a. The expiration date has passed or the expiration event is known by the UCD to have occurred;
 - b. Any material information in the authorization is known by the UCD to be false;
 - c. The authorization has not been filled out completely;
 - d. The UCD knows that the authorization has been revoked;
 - e. The authorization has been inappropriately combined with another document creating an improper compound authorization, or
 - f. The authorization has been inappropriately conditioned in violation of UCD HIPAA Policy 3.4.
8. The UCD shall not use or disclose PHI without a valid authorization, except as otherwise permitted or required in this policy and other UCD HIPAA policies.
9. There are circumstances when a use or disclosure may be performed without valid authorization.
 - a. Treatment, payment, or health care operations.
 - b. Authorization obtained prior to April 14, 2003.
 - c. When use or disclosure of PHI is required by law.

10. Compound Authorizations

An authorization for use or disclosure of PHI may not be combined with any other document to create a compound authorization, except as follows:

- a. An authorization for the use or disclosure of PHI for a research study may be combined with any other type of written permission for the same research study, including another authorization for the use or disclosure of PHI for the research or a consent to participate in the research study;
- b. An authorization for the use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes; and,

c. An authorization, other than an authorization for the use or disclosure of psychotherapy notes, may be combined with any other authorization except when UCD has conditioned the provision of treatment or payment, enrollment in a health plan, or eligibility for benefits on the provision of one of the authorizations.

Authorization to Use or Release
Health Information About Me
For Non-Research Purposes

University of Colorado Denver
School of _____
Department of _____

I _____ (Subject's Full Name) authorize
_____ (Physician Name) and staff members of

_____ (Facility Name) working for him/her to use the following
health information about me: (Please check the appropriate boxes. NOTE: If a category is checked "yes" and
a line follows the category, you MUST describe the type of the procedures done.)

No Yes

- Name and/or phone number
- Demographic information (age, sex, ethnicity, address, etc.)
- Diagnosis(es)
- History and/or Physical
- Laboratory or Tissue Studies: _____
- Radiology Studies: _____
- Testing for or Infection with Human Immunodeficiency Virus (HIV) (or results)
- Procedure results: _____
- Psychological tests: _____
- Survey/Questionnaire: _____
- Research Visit records
- Portions of previous Medical Records that are relevant to this study
- Billing or financial information
- Drug Abuse
- Alcoholism or Alcohol abuse
- Sickle Cell Anemia
- Other (Specify): _____

For the Specific Purpose of:

**If my health information that identifies me is also going to be given out to others outside the
facility, the recipients are described on the next page(s).**

- No personally identifiable health information about me will be disclosed to others**

The PHYSICIAN (or staff acting on behalf of the PHYSICIAN) will also make the following health information about me available to: (check all that apply and describe the type of the procedures done where applicable)

Recipient *(name of person or group)* _____

No Yes

All information about me (if you check this box Yes, no other boxes need to be checked in this section)
 All information about me except name, phone number, and/or address (if you check this box Yes, no other boxes need to be checked in this section)

- Name and phone number
- Demographic information (age, sex, ethnicity, address, etc.)
- Diagnosis(es)
- History and Physical
- Laboratory or Tissue Studies: _____
- Radiology Studies: _____
- Testing for or Infection with Human Immunodeficiency Virus (HIV) (or results)
- Procedure results: _____
- Psychological tests: _____
- Questionnaire/Survey: _____
- Research Visit records
- Portions of previous Medical Records that are relevant to this study
- Billing/Charges
- Drug Abuse
- Alcoholism or Alcohol
- Sickle Cell Anemia
- Other (Specify): _____

For the Specific Purpose of

- Evaluation of laboratory/tissue samples
- Data management
- Data analysis
- Other*: _____

For additional Recipients, copy this page as needed.

I give my authorization knowing that:

- I do not have to sign this authorization.
- I can cancel this authorization any time.
 - I have to cancel it in writing, and send my cancellation to: _____ at the following address: _____.
 - If I cancel it, the physician and the people the information was given to will still be able to use it because I had given them my permission, but they won't get any more information about me.
- The records given out to other people may be given out by them and might no longer be protected.
- I will be given a copy of this form after I have signed and dated it.

This authorization will expire on: _____ (Date) OR

(Describe dates or circumstances under which the authorization will expire.)

ADDITIONAL INFORMATION: _____

Subject's Signature Date

Signature of Legal Representative (If applicable) Date

Name of Legal Representative (please print)

Description of Legal Authority to Act on Behalf of Patient