

NAME OF HOSPITAL

HIPAA REGULATION	OBLIGATIONS OF COVERED ENTITIES	REFERENCE: 4.4
SUBJECT:	WRITTEN AUTHORIZATION	EFFECTIVE: 00/00/2003
DEPARTMENT:	HOSPITAL WIDE	
APPROVED BY:		REVISED:

_____ has adopted a policy on written authorizations prior to release of healthcare information to comply with our obligations under the privacy standards.

POLICY: ON AUTHORIZATIONS

It is the policy of _____ to receive authorization from a patient prior to releasing or utilizing healthcare information for purposes other than the following:

- For treatment, payment or health care operations.
- Authorization is not needed if _____ is using the notes for its own training programs in which students, trainees or practitioners in mental health learn under the supervision of organization personnel.
- Authorization is not needed if disclosure is to the individual or to a personal representative of the individual.
- Authorization is not needed to demonstrate compliance with HIPAA regulations.
- Authorization not needed to cooperate with courts, public health authorities, and law enforcement agencies or for other “public purposes.”
- For facility directories or to persons involved in the care of the individual, (provided that the individual has been given the opportunity to object to such disclosures).

The authorization form is a stand- alone document and will not be combined with any other form or document.

Please contact the person listed below with questions on this policy and/or to report violations.

Name:
Phone number:
Address:
Fax:

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APPROVED BY:		REVISED:

_____ has adopted the following procedure on written authorizations prior to release of healthcare information to comply with our obligations under the privacy standards.

PROCEDURE: TO OBTAIN WRITTEN AUTHORIZATION

- Determine if an authorization is needed from a patient to release confidential healthcare information.
- Designate the type of disclosure that will be made example: pre-employment physical, transfer of records, clinical research participation, etc.)
- Review the purpose of the authorization with the patient.
- Ask the patient to read, complete, sign and date the authorization form on the designated areas.
- Place the completed “Authorization for Disclosure of Protected Health Information” form on the patient’s medical record.
- Provide a copy of the signed authorization to the individual or personal representative.
- Explain to the patient that the authorization form can be revoked at any time. This revocation must be in writing.
- The organization must retain the signed authorization form for a period of six (6) years.

Please contact the person listed below with questions on this procedure, location of forms and/or to report violations.

Name:
Phone number:
Address:
Fax: