COUNTY OF LOS ANGELES **DEPARTMENT OF HEALTH SERVICES**

HARBOR-UCLA MEDICAL CENTER

SUBJECT: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION REQUIRING AUTHORIZATION **POLICY NO. 714**

PURPOSE:
To establish a policy and procedure applicable to all Harbor-UCLA Medical Center, programs and workforce members regarding the Use and Disclosure of Protected Health Information (PHI), and necessary authorization under the Health Information Portability and Accountability Act of 1996 (HIPAA Privacy Standards) for such use or disclosure, when the use or disclosure is for purposes outside of those permitted relating to treatment, payment, or health care operations, or under other provisions of the HIPAA Privacy Rule.

POLICY:
It is the policy of Harbor-UCLA Medical Center to obtain an individual's written authorization before using or disclosing PHI for purposes other than treatment, payment, or healthcare operations, except as permitted by the HIPAA Privacy Rule. Use and disclosure of an individual's PHI will be consistent with the valid authorization obtained from that patient.

DEFINITIONS:
Disclosure: The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Marketing: To make a communication about a product or service a purpose of which is to encourage recipients of the communication to purchase or use the product of service. Marketing excludes a communication made to an individual:

a. To describe the entities participating in a health care provider network or health plan network, or to describe if, and the extent to which, a product or service (or payment for such product or service) is provided by a covered entity or included in a plan of benefits;
b. For treatment of that individual; or
c. For case management or care coordination for that individual, or to direct or recommend alternative treatments, therapies, health care providers, or setting of care to that individual.

Protected Health Information **(PHI)**: Individually identifiable information relating to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for healthcare provided to an individual.

EFFECTIVE DATE: 4/14/03 **SUPERSEDES**
REVISED: 10/17
REVIEWED: 12/08, 10/14, 10/17
REVIEWED COMMITTEE: N/A

APPROVED BY:

Kim McKenzie, RN, MSN, CPHQ
Chief Executive Officer

Anish Mahajan, MD
Chief Medical Officer

Patricia Soltero Sanchez, RN, BSN, MAOM
Chief Nursing Officer

Signature(s) on File.

Use: With respect to PHI, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PROCEDURE:

A. The language of the authorization shall be in the form as provided in the **DHS Authorization for Use or Disclosure of Protected Health Information Form** ("Authorization Form").

B. **Required Elements** - To be valid, an authorization must contain the elements listed below:

1. **Description of PHI:** A specific, meaningful description of the PHI to be used or disclosed;
2. **Identity of Disclosing Party:** The name or other specific identification of the person(s) or class of persons authorized to disclose the PHI;
3. **Identity of the Recipient:** The name or other specific identification of the person(s), or class of persons authorized to use or otherwise receive the PHI;
4. **Purpose of Use or Disclosure:** A description of each purpose of the requested use or disclosure, including limitations on the recipient's use of the PHI, if any;
    a. The statement "at my request" by the patient is a sufficient description for an authorization initiated by the patient.
5. **Expiration Date:** The end date for the permission granted by the authorization, which must be a specific date or event after which Harbor-UCLA Medical Center is no longer authorized to disclose the PHI.
6. **Statement of Right to Revoke:** The authorization must include a statement that the individual has a right to revoke the authorization. The statement must also explain how revocation is accomplished, including that it must be in writing, and tell the individual about exceptions applicable to the revocation. The exceptions are listed in "Implementation of Revocation."
7. **Signature:** Signature of the individual and date of signature. An authorization signed by a personal representative of the individual must include a description of the personal representative's authority to act for the individual.
8. **Authorization as a Condition:** The authorization must state that Harbor-UCLA Medical Center cannot condition treatment, payment, enrollment in the health plan, or eligibility for benefits on obtaining a signed authorization, except:
9. **Redisclosure:** The authorization must state that the PHI disclosed to others may not be further used or disclosed by the recipient unless a new authorization is signed by the individual, or such use or disclosure is specifically required or permitted by law.
10. **Copy:** The authorization must state that an individual signing the authorization has the right to receive a copy of it;

C. Harbor-UCLA Medical Center shall provide the Authorization Form upon a patient's request or in conjunction with any authorization initiated by Harbor for the Disclosure of PHI.

D. If the patient initiates the authorization, Harbor-UCLA Medical Center shall establish the identity of the requestor in accordance with the Verification of Identity and Authority Policy and Procedure.

E. Harbor-UCLA Medical Center shall explain the Authorization language to the patient or personal representative, and obtain signatures on the Authorization Form.

F. Harbor-UCLA Medical Center shall ensure that all required elements listed above are completed.

G. **Patient Given Copy:** Harbor-UCLA Medical Center shall provide a copy of the signed Authorization Form to the patient or personal representative.

H. Compound Authorizations: A HIPAA authorization applies only to the Use or Disclosure of PHI and may be combined with another type of written permission only as follows:
An authorization for use and disclosure of PHI for a research study may be combined with any other written permission for the same research study, such as the patient consent to participate in the research study, so long as the HIPAA authorization portion is clearly separate from any other language present on the same page and is executed by a signature for the sole purpose of executing the authorization.

I. Defective Authorization: An authorization is not valid, or is no longer valid, and may not be relied upon to use or disclose PHI, if:

1. The expiration date has passed;
2. Any required element for a valid authorization is missing;
3. Harbor-UCLA Medical Center has received written revocation of the authorization;
4. Harbor-UCLA Medical Center knows that important information in the authorization is false;
5. The authorization violates restrictions on compound authorizations as set forth in Section H above.

J. Conditions: Harbor-UCLA Medical Center may not condition the individual's treatment upon an authorization except:

1. Harbor-UCLA Medical Center may condition research-related treatment on provision of a HIPAA authorization for Use or Disclosure of PHI.
2. Harbor-UCLA Medical Center may not condition the provision of health care on obtaining an authorization even if the only purpose of providing the health care is to create PHI for disclosure to a third party (e.g. fitness for duty, school or summer camp physical, pre-employment examinations).
    a. Harbor-UCLA Medical Center will disclose the PHI directly to the patient, unless Harbor receives a signed HIPAA authorization from the patient for the Disclosure to the third party.

K. Authorization for Marketing

1. Harbor-UCLA Medical Center must obtain an Authorization for any Use or Disclosure of PHI for marketing, except if the marketing communication is in the form of:
    a. Face-to-face communications to the patient by Harbor-UCLA Medical Center; or
    b. A gift to the patient from Harbor-UCLA Medical Center of nominal value, e.g., a pen with a Harbor-UCLA Medical Center logo.
    If the marketing involves direct or indirect remuneration to Harbor-UCLA Medical Center from a third party, the Authorization must state that such remuneration is involved.

L. Implementation of Revocation

1. A patient may revoke or modify his or her authorization in writing.
2. A modification or revocation is valid, except to the extent Harbor-UCLA Medical Center has taken action in reliance on such Authorization.
3. The individual may use the Revocation of Authorization at the bottom of the Authorization Form, or write their own revocation.

M. Use and Disclosure of HIV Test Results: Except as specifically set forth below, HIV test results, whether positive or negative, or even the fact that an HIV test was ordered, may be disclosed only pursuant to a valid, written authorization.

1. **Use and Disclosure of HIV Test Results Pursuant to a Written Authorization:** To be valid, an authorization for Use or Disclosure of an HIV test result must be signed by the same individual who validly signed the consent for the HIV test and who is one of the following:
    a. Adult with medical decision-making capacity;
    b. A minor who is twelve (12) years of age or older and mature enough to give effective informed consent to an HIV test.
    c. A parent or legal guardian for a minor under twelve (12) years of age; or
    d. A conservator or agent pursuant to a power of attorney for health care.
2. **Requirements for a Written Authorization for Use or Disclosure of HIV Test Results**
    a. To be valid, an authorization for Use or Disclosure of HIV test results must contain all of the elements set forth in Section B under "Procedures".
    b. Additionally, the authorization must specifically state that it authorizes the Use or Disclosure of HIV test results and must be signed by a witness.
    c. A general authorization for the Use or Disclosure of medical records is *not* sufficient to authorize Use or Disclosure of HIV test results.
    d. If only a general authorization for Use or Disclosure of medical information is received that does not specifically authorize the Use or Disclosure of HIV test results, the HIV test results must be redacted from the information that is Used or Disclosed (if any) and may *not* be Used or Disclosed.
    e. A separate written authorization must be obtained for each use or disclosure of an HIV test result.
3. **Exceptions to the Written Authorization Requirement:** HIV test results may, but are not required to, be disclosed to the following persons without the written authorization of the test subject:
    a. The subject of the test or the subject's legal representative, conservator, or to any person authorized to consent to the test;
    b. The subject's provider of health care for the purpose of diagnosis, care, or treatment of the patient (but not to a health care service plan);
    c. An agent or employee of the test subject's provider of health care who provides direct patient care and treatment;
    d. A provider of health care who procures, processes, distributes, or uses a human body part donated pursuant to the Uniform Anatomical Gift Act, as well as to a procurement organization, a coroner, or a medical examiner in conjunction with such donation;
    e. The "designated officer" of an emergency response employee, or from that designated officer to an emergency response employee, regarding possible exposure to HIV or AIDS, but only to the extent necessary to comply with the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (42 U.S.C. § 201).
    f. In some instances, to a health care worker who has been exposed to the potentially infectious materials of a patient, provided that strict procedures for consent and testing are followed. Legal counsel should be consulted with regard to such disclosures;
    g. A court pursuant to a court order for Disclosure of HIV test results of a defendant to a criminal charge; and
    h. A county health officer (without identifying the individual believed to be infected).
4. **Disclosure to Persons at Risk of Infection:** In addition to the foregoing, a patient's physician may, but is not required to, disclose a positive HIV test result to specified individuals under

circumstances indicating that such individual may be in danger of HIV infection.

a. The physician may make a Disclosure to the following:
   i. Any person known or believed to be the spouse of the test subject;
   ii. Any person known or believed to be a sexual partner of the test subject; and
   iii. Any person known or believed to have shared hypodermic needles with the test subject.

b. Before disclosing test results under this provision, the physician must do the following:
   i. Provide appropriate education and psychological counseling for the test subject;
   ii. Inform the test subject of the physician's intent to notify such person; and
   iii. Attempt to obtain voluntary consent from the test subject. If consent cannot be obtained, the results may then be disclosed but only for the purpose of obtaining care, follow-up, and/or treatment for the person(s) to whom disclosure is made and to interrupt the chain of infection.

c. The disclosing physician must refer the person notified for appropriate care, counseling, and follow-up. The physician ***may not*** disclose any identifying information about the test subject.

N. Document Retention: Harbor-UCLA Medical Center shall document and retain all documents required to be created or completed by this policy.

1. Signed Authorizations must be retained for at least 6 years after the date they were last in effect.
2. Revoked Authorizations and revocation documents must be retained for at least 6 years after the date Harbor-UCLA Medical Center receives revocation documents.

O. Forms

1. Forms referenced in this policy may be obtained by accessing the Harbor Shared Point Intranet Website, under Forms.
   a. Authorization for Use or Disclosure of Protected Health Information

REFERENCES:

1. 45 Code of Federal Regulations Parts 160 and 164; Section 164.508 "Uses and Disclosures for which an Authorization is Required".
2. Cal. Civil Code Cal. Civil Code §§ 56.11(b), (g), (h), and (i), § 56.12, § 56.17(g)(8), § 56.245, § 56.31, § 56.37(a)
3. Cal. Health & Safety Code § 120980(g).
4. Cal. Welf. & Inst. Code §§ 5328(b) and (d).

ATTACHMENT A
DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Last Name First MI | Date of Birth (Mo/D/Yr) | Medical Record Number

HEREBY AUTHORIZES:

- ☐ LAC+USC Medical Center
- ☐ Harbor-UCLA Medical Center
- ☐ King Drew Medical Center
- ☐ Olive View Medical Center
- ☐ High Desert Hospital
- ☐ CHC/Health Center: _____
- ☐ Other: _____

To Release Protected Health Information To:

Name of Facility/Health Care Provider/Plan/Other

Street Address

City State Zip Code

for the time period beginning, _____ (DATE), and ending _____ (DATE).

INFORMATION TO BE DISCLOSED

PLEASE CHECK ALL APPROPRIATE BOXES:

- ☐ Summary Of Medical History / Treatment
- ☐ Laboratory / Diagnostic Tests
- ☐ Discharge Summary
- ☐ Consultation
- ☐ Psychological Testing
- ☐ HIV/AIDS,
- ☐ Sexually Transmitted Disease(s)
- ☐ Mental Illness Or Mental Health Assessment
- ☐ Drug and/or Alcohol Abuse Treatment.
- ☐ Other (Please Specify)
- ☐ History and Physical
- ☐ Medical Progress Notes
- ☐ Radiology Records
- ☐ Radiology Films
- ☐ EKG Report
- ☐ EEG Report
- ☐ Operative Report

THE PURPOSE OF THE DISCLOSURE - PROVIDE A DESCRIPTION OF THE PURPOSE OF INTENDED USE AND DISCLOSURE

I understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: _____ / _____ / 20___

DEPARTMENT OF HEALTH SERVICES
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YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DHS in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

_____

_____

_____

_____

I also understand that a revocation will not affect the ability of DHS or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DHS may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Of Patient/Legal Representative: _____

If signed by other than the patient, state relationship and authority to do so:

_____

DATE: _____/_____/_____ **WITNESS:** _____
Month Day Year

REVOCATION OF AUTHORIZATION

Signature Of Patient/Legal Representative: _____

If signed by other than patient, state relationship and authority to do so:

_____

DATE: _____/_____/_____
Month Day Year

Approved 3/03

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COUNTY OF LOS ANGELES

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FOR OFFICE USE ONLY:

INFORMATION REQUESTED	DATES
1. ALL RECORDS	
2. DISCHARGE SUMMARY	
3. RADIOLOGY REPORT	
4. RADIOLOGY FILM	
5. EKG REPORT	
6. EEG REPORT	
7. PSYCHOLOGICAL TESTING	
8. OPERATIVE REPORT	
9. PATHOLOGY REPORT	
10. PROGRESS NOTES	
11. CONSULTATION	
12. LABORATORY REPORT	
13. OTHER	

SENT BY:	DATE SENT:

{DHS Facility Name and Address}	MEDICAL RECORD NUMBER NAME
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION	DOB

Approved 3/03