Envision HEALTHCARE	Ethics & Compliance Department		
	Policy No.: 39	**Created:**	01/2018
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		Revised:	

HIPAA: AUTHORIZATION REQUIREMENTS

SCOPE:

All Envision Healthcare teammates. For purposes of this policy, all references to "teammate" or "teammates" include temporary, part-time and full-time employees, independent contractors, clinicians, officers and directors.

PURPOSE:

Envision Healthcare Operating, Inc. and its subsidiaries and affiliates ("Envision" or "the Company") has adopted this Authorization Requirements policy to outline the Company's requirements for patient authorization related to the use and disclosure of PHI.

POLICY:

General Requirements

Except for the uses and disclosure identified in Policy 25 – Restriction of Use or Disclosure, the Company will not use or disclose PHI that was received or created outside the process of providing treatment, payment, or health care operations, without an authorization from the patient. When the Company obtains or receives a valid authorization for its use or disclosure of PHI, such use or disclosure must be consistent with such authorization.

A) The Company will not obtain a patient's authorization to disclose PHI when required by law, as part of health oversight activities, for the purpose of identifying a deceased person, or when a waiver is granted for the purposes of a research project.

Defective Authorizations

A) An authorization is not valid, if the document submitted has any of the following defects:

(1) The expiration date has passed, or the expiration event is known by the covered entity to have occurred;

(2) The authorization has not been filled out completely;

(3) The authorization has been revoked;

(4) The authorization does not contain all the required elements as defined in this policy;

(5) Any material information in the authorization is known to be false.

Conditioning of Authorizations

A) The Company will not condition treatment on the provision of an authorization, except that the Company may condition the provision of "research-related" treatment on provision of an authorization.

B) The Company may also condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. For example, the Company may have a contract with an employer to provide fitness-for-duty exams, or a contract with a life-insurer to provide pre-enrollment physicals for applicants. In each of these cases, the Company would condition the health care services on provision of an authorization.

Revocation of Authorizations

A) The Company will allow a patient to revoke an authorization at any time, provided that the revocation is in writing, except to the extent that the Company has taken action in reliance thereon.

Documentation Requirements

A) The Company will retain any signed authorization and related documentation for six (6) years from the signed date of the authorization.

B) The Company will provide the patient with a copy of the authorization.

C) The authorization must be written in plain language.

Core Elements and Requirements

A) The authorization must contain the following elements:

(1) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;

(2) The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;

(3) The name or other specific identification of the person(s), or class of persons, to whom the Company may make the requested use or disclosure;

(4) An expiration date or an expiration event that relates to the patient or the purpose of the use or disclosure;

(5) A statement of the patient's right to revoke the authorization in writing and the exceptions to the right to revoke, together with a description of how the patient may revoke the authorization;

(6) A statement that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule;

(7) Signature of the patient and date; and

(8) If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient.

See "Authorization to Release Health Information," form attached below.

B) If the Company requests the authorization for its own uses, or for the use or disclosure by others, the following apply:

(1) A statement that the Company will not condition treatment on the patient's providing authorization for the requested use or disclosure;

(2) A description of each purpose of the requested use or disclosure;

(3) A statement that the patient may inspect or copy the protected health information to be used or disclosed, and refuse to sign the authorization;

(4) If use or disclosure of the requested information will result in direct or indirect remuneration to the Company from a third party, a statement that such remuneration will result; and

(5) A statement that the patient may refuse to sign the authorization.

Compound Authorizations

A) The Company will not combine any authorizations for use or disclosure with a consent for treatment or payment or with an informed consent to participate in research.

B) The Company may combine an authorization for use or disclosure of PHI and another document to create a compound authorization as follows:

(1) An authorization created for research that includes treatment of the patient may be combined with a consent for use or disclosure, another research consent, or a Notice of Privacy Practices;

(2) An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes; and

(3) An authorization, other than an authorization for disclosure of psychotherapy notes, may be combined with any other authorization, except when treatment is conditioned on the provision of one of the authorizations.

(4) An authorization for disclosure of PHI for a research study can be combined with any other type of written permission for the same or another research study, with an authorization for the creation or maintenance of a research database or repository or with a consent to participate in research.

C) If authorizations are combined as described in this policy, each authorization must be visually and organizationally separate from other content within the document, and it must be separately signed and dated.

POLICY REVIEW

The Ethics & Compliance Department will review and update this Policy, when necessary, in the normal course of its review of the Company's Ethics & Compliance Program.

Envision HEALTHCARE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name:
Patient Address:
Date of Birth (mm/dd/yy): Patient's Phone:
Other Identifier (Last 4 digits of Social Security #):

I AUTHORIZE _____

TO DISCLOSE MY HEALTH INFORMATION TO: _____

Name of person or organization:

To the Attention of:

Street Address of Entity:

City: State: Zip: Phone or Email of Recipient:

Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ *(insert dates)*:

☐ The following medical records:

❑ Discharge summary	❑ Progress notes
❑ Lab results	❑ Photographs, videotapes, or other images
❑ History and physical exam	❑ Mental or behavioral health records
❑ Consultation reports	❑ Psychotherapy notes
❑ X-ray reports	❑ Genetic test results
❑ HIV/AIDS test results and treatment	❑ Entire medical record
❑ Alcohol and drug treatment records	❑ Summary of treatment
❑ Operative record	❑ Other (specify):

☐ The following billing and payment information:

_____

_____

☐ Other information: _____

_____

REASON FOR REQUESTED USE OR DISCLOSURE:

TO BE READ AND SIGNED BY PATIENT OR LEGAL REPRESENTATIVE:

I understand the following:

a. I may revoke this authorization at any time by providing written notice.
b. I may not be able to revoke this authorization if the company has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. I understand that I may refuse to sign this Authorization and that the company will not condition treatment on whether I sign this Authorization.
d. I am signing this authorization freely and no one has pressured me to sign this authorization.
e. The information disclosed in this authorization may be subject to re-disclosure by the receiving party and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
g. Expiration: I understand that unless I revoke the authorization earlier, this authorization will automatically expire one (1) calendar year after the date this authorization is signed.

Patient Signature: Date:

Signature of Patient's Representative: Relationship: Date:

FOR OFFICE USE ONLY:

Event or Date Upon Which Authorization Will Expire:

If no date is specified, this authorization will expire within 1 year of the date above.