LSU HEALTH CARE SERVICES DIVISION
BATON ROUGE, LA

POLICY NUMBER: 7501-24

CATEGORY: HIPAA Policies

CONTENT: Use and Disclosure of Protected Health Information that Require an Individual's Written Authorization

- Listing of "Permitted" or "Required" Use of Disclosure (Attachment A)
- Authorization Form (Attachment B)

APPLICABILITY: This policy is applicable to the Health Care Services Division Administration (HCSDA) and Lallie Kemp Medical Center (LKMC) to include employees, physician/practitioner practices, vendors, agencies, business associates and affiliates.

EFFECTIVE DATE:

Issued:	April 14, 2003
Revised:	December 7, 2007
Revised:	January 26, 2009
Reviewed:	August 13, 2010
Reviewed:	March 23, 2012
Revised:	July 23, 2013
Revised:	May 8, 2014
Revised:	February 12, 2015
Reviewed:	February 23, 2016
Reviewed:	August 28, 2017
Reviewed:	January 8, 2020
Reviewed:	August 16, 2022
Reviewed:	August 4, 2023
Reviewed:	September 21, 2023
Reviewed:	October 18, 2023
Reviewed:	November 12, 2024

INQUIRIES TO: LSU Health Care Services Division
Compliance Section
Post Office Box 91308
Baton Rouge, LA 70821-1308

Note: Approval signatures/titles are on the last page

LSU HEALTH CARE SERVICES DIVISION
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THAT REQUIRE AN INDIVIDUAL'S WRITTEN AUTHORIZATION

I. STATEMENT OF POLICY

To provide guidance to the health care facilities and providers affiliated with LSU Health Care Services Division (HCSD) on the requirement to obtain a patient's written authorization to use or disclose the patient's Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (HIPAA Privacy Regulations), and any other applicable state or Federal laws or regulations.

All HCSD facilities and providers must obtain a patient's written authorization when required by the HIPAA regulations to do so.

Note: Any reference herein to the Health Care Services Division (HCSD) also applies and pertains to Lallie Kemp Medical Center (LKMC).

II. IMPLEMENTATION

This policy and subsequent revisions to the policy shall become effective upon approval and signature of the HCSD Chief Executive Officer (CEO) or Designee.

III. DEFINITIONS

A. **Protected Health Information (sometime referred to as "PHI")** – for purposes of this policy means individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. Includes demographic data that relates to:

1. The individual's past, present or future physical or mental health or condition;
2. The provision of health care to the individual; or
3. The past, present, or future payment for the provision of health care to the individual, and that identified the individual or for which there is a reasonable basis to believe it can be used to identify the individual. PHI includes many common identifiers such as name, address, birth date, social security number, etc.

B. **Disclosure** - For purposes of this policy, means the release, transfer, and provision of access to PHI outside of the Facility or Clinic.

C. **Use** – For purposes of this policy, means with respect to PHI, the sharing, utilization, or examination of Protected Health Information within and by employees or agents of

Facility or Clinic.

IV. PROCEDURE

A. An individual's written authorization must be obtained prior to using or disclosing the individual's Protected Health Information, unless the particular Use or Disclosure is listed in Attachment A of this policy as a "Permitted" or a "Required" Use or Disclosure.

B. If a signed authorization is required for a particular Use or Disclosure, then either the attached "Authorization" form (as Attachment B) or an authorization form that contains all of the "Authorization Form Content Requirements" listed in 3 below must be used when obtaining an individual's authorization.

Examples of disclosures that require an Authorization include, but are not limited to:

1. Release of psychotherapy notes, (except to the originator of the notes);
2. For marketing purposes;
3. To release health information to an employer as part of a background check;
4. To release information to an insurance company at the patient's request for underwriting or eligibility for benefits (e.g. life or disability insurance); and
5. To release medical records to an attorney at the request of the patient.

C. Authorization Form Content Requirements

A valid authorization must contain at least the following information and statements and be written in plain language:

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 Facility or Clinic may make the requested disclosure;

4. A ***description of each purpose*** of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

5. An ***expiration date or an expiration event*** that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none" or similar language is sufficient if the authorization is for a use or disclosure of PHI for research, including for the creation and maintenance of

a research database or research repository; and

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

In addition to the above information, the authorization form must contain statements with the following information:

1. The individual's right to revoke the authorization in writing, and either: (a) the exceptions to the right to revoke and a description of how the individual may revoke the authorization; or (b) a reference to the Facility's or Clinic's notice of privacy practices;
2. The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the patient signing the authorization, by stating either:

    a. The Facility or Clinic may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations contained in the HIPAA Privacy Regulations is applicable; or
    b. The consequences to the individual of a refusal to sign the authorization when the Facility or Clinic can condition treatment, enrollment in the health plan, or eligibility for benefits on obtaining such an authorization; and

3. The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer be protected by the HIPAA Privacy Regulations.

A valid authorization may contain other information in addition to the required elements, provided that such additional information does not conflict with the required information and statement.

D. Psychotherapy Notes**:** A signed authorization form must be obtained for any use or disclosure of psychotherapy notes, except in the following situations:

To carry out the following treatment, payment, or health care operations:

1. Use by the originator of the psychotherapy notes for treatment;
2. Use or disclosure by Facility or Clinic for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;

3. Use or disclosure by Facility or Clinic to defend itself in a legal action or other proceeding brought by the individual; or
4. Use or disclosure that is required or permitted with respect to the oversight of the originator of the psychotherapy notes.

Important Note: The facility or clinic may not disclose psychotherapy notes for purposes of another covered entity's treatment, payment, or health care operations without obtaining the individual's written authorization.

E. Marketing**:** A signed authorization must be obtained for any use or disclosure of PHI for purposes deemed to be marketing by HIPAA, except if the communication is in the form of:

1. A face-to-face communication made by our Facility or Clinic to an individual; or
2. A promotional gift of nominal value provided by Facility or Clinic.

If the marketing involves direct or indirect remuneration to the Facility or Clinic from a third party, the authorization must state that such remuneration is involved. The authorization must also contain a statement that the patient may revoke the authorization at any time to stop receiving the marketing material.

F. Sale of PHI**:** HIPAA prohibits the sale of PHI (either direct or indirect remuneration) without the signed authorization of the patient. The authorization must include a statement that the entity is receiving direct or indirect remuneration in exchange for the PHI.

G. Invalid Authorizations**.** The Facility or Clinic cannot accept an authorization that contains any of the following defects:

1. The expiration date has passed or the expiration event is known by our Facility or Clinic to have occurred;
2. The authorization has not been filled out completely, with respect to information that is required for a valid authorization form;
3. The authorization is known by the Facility or Clinic to have been revoked;
4. The authorization violates any requirements of this policy, such as specifications regarding compounding or conditioning authorizations; or
5. Any material information in the authorization is known by our Facility or Clinic to be false.

H. 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:

1. 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 such research or a consent to participate in such research; or

2. A conditioned and unconditioned authorization for the use or disclosure of PHI for a research study may be combined if the authorization clearly differentiates between the conditioned and unconditioned research components and clearly allows the individual the option to opt in to the unconditioned research activities.
3. 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; or
4. An authorization under this section, other than an authorization for the use or disclosure of psychotherapy notes, may be combined with any other such authorization under this section, except when Facility or Clinic has conditioned the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits under this section on the provision of one of the authorizations.

I. Prohibition on Conditioning of Authorizations**:** The Facility or Clinic may not condition treatment, payment, enrollment in our health plan, or eligibility for benefits to an individual on the signing of an authorization, except in the following circumstances:

1. Facility or Clinic may condition the provision of research-related treatment on the signing of an authorization for the use or disclosure of PHI for research; or
2. Facility or Clinic may condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party on the signing of an authorization for the disclosure of the PHI to such third party.

J. Revocation of an Authorization**.** An individual may revoke his or her authorization at any time, provided that the revocation is in writing, ***except*** to the extent that:
1. Facility or Clinic has taken action in reliance on the signed authorization; or
2. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

K. Documentation Requirements**:** The Facility or Clinic must retain copies of all signed authorization forms for six (6) years from the date the authorization was last in effect. The authorization forms may be retained in paper or electronic format.

L. Copy of Authorization**:** If the Facility or Clinic sought the authorization from the patient, then the Facility or Clinic must provide the individual with a copy of the signed authorization form.

V. EXCEPTION

The HCSD CEO or designee may waive, suspend, change or otherwise deviate from any provision of this policy deemed necessary to meet the needs of the agency as long as it does not violate the intent of this policy, state and/or federal laws Civil Service Rules and Regulations, LSU Policies/Memoranda, or any other governing body regulations.

Attachment A

The "Permitted" and "Required" Uses or Disclosures of Protected Health Information listed in this attachment do NOT require an individual's signed authorization.

PERMITTED USES AND DISCLOSURERS OF PROTECTED HEALTH INFORMATION

1. Disclosing the individual's Protected Healthcare Information **to the individual**.
2. Using and disclosing the individual's Protected Health Information for **treatment reasons, to obtain payment, or for health care business operations.**
3. **Incident to a use or disclosure** otherwise permitted or required by the HIPAA Privacy Regulations (e.g. overheard conversations at nursing stations, sign-in sheets).
4. Disclosures of Protected Health Information **in response to a signed authorization** that the patient has signed for our facility or clinic to release his or her Protected Health Information to another entity.
5. Disclosures of Protected Health Information **pursuant to an oral agreement with the individual** to make such disclosures to a relative or friend (e.g. family member, friend, or other.)
6. Uses or Disclosures of Protected Health Information that are **required by law**.
7. Disclosure of Protected Health Information **for public health activities**.
8. Disclosure of Protected Health Information **about an individual whom the facility or clinic reasonably believe to be a victim of abuse, neglect**, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.
9. Disclosure of Protected Health Information **to a health oversight agency** for oversight activities authorized by law (e.g. professional boards).
10. Disclosure of Protected Health Information in the course of any **judicial or administrative proceeding**. (An authorization is not needed, but the disclosure must comply with other requirements of the privacy regulations for judicial disclosures and any state law requirements).
11. Disclosure of Protected Health Information **for a law enforcement purpose to a law enforcement official in specific circumstances, as provided for in the HIPAA regulation.**
12. Disclosure of Protected Health Information **in response to a law enforcement official's request** for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.
13. Disclosure of Protected Health Information **in response to a law enforcement official's request** for such information about an individual who is or is suspected to be a victim of a crime.

14. Disclosure of Protected Health Information **about an individual who has died to a law enforcement official** for the purpose of alerting law enforcement of the death of the individual if the facility or clinic has a suspicion that such death may have resulted from criminal conduct.

15. Disclosure **to a law enforcement official** of Protected Health Information that the facility or clinic believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the facility or clinic.
16. If the facility or clinic is providing **emergency health care in response to a medical emergency**, other than such emergency on the premises of the facility or clinic, the facility or clinic may disclose Protected Health Information to a law enforcement official if such disclosure appears necessary to alert law enforcement.
17. The facility or clinic may disclose Protected Health Information **to a coroner** or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
18. Disclosure of Protected Health Information **to funeral directors**, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
19. Use or disclosure of Protected Health Information to **organ procurement organizations** or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.
20. The facility or clinic may use or disclose Protected Health Information, if the facility or clinic, in good faith, believes the use or disclosure: (A) is necessary to prevent or lessen a **serious and imminent threat to the health safety of a person or the public**; (B) is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or, (C) is necessary for law enforcement authorities to identify or apprehend an individual.
21. The facility or clinic may disclose Protected Health Information as authorized by and to the extent necessary to comply with Louisiana **workers' compensation** statutes.
22. The facility or clinic may disclose Protected Health Information concerning **specialized government functions**, such as information about armed forces personnel if deemed necessary by appropriate military command authorities, and for **national security and intelligence activities.**
23. To disclose protected health information to **correctional institutions and other law enforcement custodians** if such information is necessary to provide healthcare to those inmates or provide for the health and safety of the individual or other inmates and employees of the correction institution.
24. Use and disclosure for **research purposes,** if certain criteria are met (see Use and Disclosure of PHI for Research policy).
25. The facility or clinic may use, or disclose to a HIPPA Business Associate the following Protected Health Information for the purpose of raising funds for the facility or clinic's own benefit, without an authorization:
    a. Demographic Health Information relating to an individual; and,
    b. Dates of health care provided to an individual.

    However, the patient must be provided the ability to opt out of any fund raising communication after receiving such a request.

REQUIRED DISCLOSURES
OF PROTECTED HEALTH INFORMATION

1. To an individual, when requested under, and as **required by the access or accounting requirements** of the HIPAA Privacy Regulations.
2. When required by the Secretary of the Department of Health and Human Services **to investigate or determine the** facility's or clinic's compliance with the HIPAA Privacy Regulations.

Attachment B

Authorization for Release of Protected Health Information

Patient Identification

Printed Name: _____ **Date of Birth:** _____

Address: _____

_____

Social Security #: _____ Telephone: _____

Authority to Release Protected Health Information

I hereby authorize _____ to release the information identified in this authorization form from the medical records of _____ and provide such information to _____.

.

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

☐ Complete health record	☐ Diagnosis & treatment codes	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ X-ray reports	☐ X-ray films / images
☐ Photographs, videotapes	☐ Complete billing record	☐ Itemized bill

☐ Other, (specify)

_____

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be "at the request of the individual"):

_____

_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:** ☐ **Yes** ☐ **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check One:** ☐ **Yes** ☐ **No**

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to _____ at _____ . Unless revoked, this authorization will expire on the following date, or after the following time period or event _____

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if healthcare services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test). I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. **I hereby release and discharge _____ of any liability and the undersigned will hold _____ harmless for complying with this Authorization.**

Signature: _____ **Date:** _____

Description of relationship if not patient:

_____

NOTE: This example does not include the statements required for the sale of PHI or remuneration for marketing.

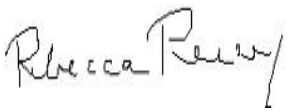
Document Metadata

Document Name:	7501-24 Use and Disclosure of PHI that Requires Written Authorization.doc
Policy Number:	7501
Original Location:	/LSU Health/HCSD/7500 - HIPAA
Created on:	04/14/2003
Published on:	11/15/2024
Last Review on:	11/12/2024
Next Review on:	11/12/2025
Effective on:	04/14/2003
Creator:	Townsend, Kathy *HCSD Human Resources Director*
Committee / Policy Team:	Main Policy Team
Owner/SME:	Simien, Tammy *Staff Attorney*
Manager:	Reeves, Rebecca *Compliance and Privacy Officer*
Author(s):	Wicker, Claire M. *PROJECT COORDINATOR* Reeves, Rebecca *Compliance and Privacy Officer* Simien, Tammy *Staff Attorney*
Approver(s):	Wilbright, Wayne *Chief Medical Informatics Officer* Reeves, Rebecca *Compliance and Privacy Officer* Simien, Tammy *Staff Attorney*
Publisher:	Wicker, Claire M. *PROJECT COORDINATOR*

Digital Signatures:

Currently Signed

Approver:
Reeves, Rebecca
Compliance and Privacy Officer



11/14/2024

Approver:
Simien, Tammy
Staff Attorney

11/15/2024

Approver:
Wilbright, Wayne

11/15/2024