Red Cliff Health Services
Policy and Procedure for Authorization for Use or Disclosure of Protected Health Information –RCHS FORM 810
45 CFR 164.502, 164.508

PURPOSE: To establish a policy and procedure for using or disclosing protected health information (PHI) pursuant to the client's authorization in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, 45 CFR Part 164.

P0LICY: An "Authorization for Use or Disclosure of Health Information" Form RCHS Form 810 or another valid authorization form must be completed and signed (original signature) prior to the use or disclosure of PHI for any purpose other than treatment, payment, or healthcare operations or other purposes for which uses and disclosures without an authorization are permitted or required under the privacy regulations..

PROCEDURE: The following procedures will govern how PHI will be used or disclosed pursuant to a valid authorization (RCHS Form-810) received by The Red Cliff Health Services (RCHS).

1. Only authorizations with original signatures will be processed by the Health Information Management (Medical Records Department).

2. Blanket authorizations (no specified client or organization authorized to make the requested use or disclosure), authorizations that have not been filled out completely, or duplicated authorizations will not be honored.

3. A client may authorize a use or disclosure of PHI by completing and signing the Authorization, RCHS Form-810, or another valid authorization.

4. Verification of the identity of the client or other individual requesting the use or disclosure will be performed. (See P&P on Verification of Identify Prior to Disclosure of PHI).

5. If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be documented. Legal documents must be filed in the client's record as appropriate.

6. When an authorization for use or disclosure of PHI is incomplete or unclear, RCHS will not use or disclose PHI pursuant to the authorization.

7. *Information disclosed by an alcohol or other drug abuse treatment program must be accompanied by the following statement: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

8. A copy of the signed authorization, RCHS FORM 810, will be provided to the client and the original signed authorization or written request will be filed in the client's record.

RED CLIFF HEALTH SERVICES
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715-779-3707

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Complete all sections, date, and sign

I. I, ____, hereby voluntarily authorize the use or disclosure of my protected health information as described below.

II. The use or disclosure is to be made by:
Name of Facility:____
Address: ____
City/State: ____

The use or disclosure is to be made to:
Name of Person/Organization/Facility: ____
Address: ____
City/State: ____

III. The purpose for this use or disclosure is:
____

IV. The information to be used or disclosed is the following: (check appropriate box (es))
Entire Record
Information related to (*specify*): ____
Information from:_______________________to_______________________
Other (specify): ____
Psychotherapy Notes ONLY

I authorize the following sensitive information to be used or disclosed, (check the applicable box (es) below).
Alcohol/Drug Abuse Treatment/Referral
HIV/AIDS-related Treatment
Sexually Transmitted Diseases
Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that the Red Cliff Health Services has taken action in reliance on this authorization.

This authorization expires on ___________________ (insert date, time period or event)
I understand that the Red Cliff Health Services will not condition treatment on my signing this authorization.
I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations [45 CFR Part 164].

Non-Custodial Parents/Parent's denied physical placement: Under Wisconsin Statue 146.835.A parent or legal guardian has the legal authority to access and receive copies of a minor child's health information and consent for medical treatment. However, a non custodial parent does not have the legal authority to access and/or obtain copies of a minor child's health care records and consent to medical care. A non-custodial parent is 1) a health Care Center's staff reserves the right to require a parent to provide legal documentation (court order) making this legal determination. In situations where the parent who has had their rights terminated/non custodial parent and has been court ordered to provide the minor child with health insurance, then the parent is allowed to obtain copies of the minor child's billing information and nothing more.

Authorized Signature: ____ _______________________
Date

Signature of Witness:____ _______________________
Date

The Red Cliff Health Services can honor a request only if this form is filled out completely.

PATIENT NAME (Last, First MI) ____CHART#_________________

DATE OF BIRTH:____

RCHS FORM-810 Revised (02/06/06)

INSTRUCTIONS TO COMPLETE RCHS Form 810, "AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION"

1. Print legibly in all fields using ink.
2. Section I, print name of client whose information is to be released.
3. Section II, print the name and address of the facility authorized to make the requested use or disclosure of the information. Also, provide the name and address of the person or organization to which the use or disclosure of information may be made.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, etc.
5. Section IV; check the appropriate box as applicable.

    a. **Entire Record** - the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)
    b. **Only information related to** - specify diagnosis, injury, operations, special therapies, etc.
    c. **Only the period of events from** -- specify date range, e.g., Jan 1, 2002 to Feb 1, 2002.
    d. **Other (specify)** - e.g., CHS, billing, employee health, etc.

    e. Psychotherapy Notes ONLY **- IN ORDER TO RELEASE PSYCHOTHERAPY NOTES, ONLY THIS BOX MUST BE CHECKED ON THIS FORM. NO OTHER REQUESTS FOR INFORMATION CAN BE MADE IN CONJUNCTION WITH PSYCHOTHERAPY REQUESTS.**
    IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED. AN ADDITIONAL AUTHORIZATION MUST BE USED TO RELEASE PSYCHOTHERAPY NOTES ONLY.

    Psychotherapy notes are often referred to as progress notes, distinguishable from progress notes in the medical record. These notes capture the impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

    f. **In order to release sensitive information, alcohol/drug abuse treatment/referral, hiv/aids-related TREATMENT, sexually transmitted diseases, mental health (other than psychotherapy notes); you must check the appropriate box!**

6. Section V, client sign and date.
7. Section V, Authorized Representative, e.g., a parent signing for minor children, legal guardians, power of attorney, etc., sign and date if applicable.
8. A copy of the completed RCHS Form-810 or other valid authorization will be given to the client.