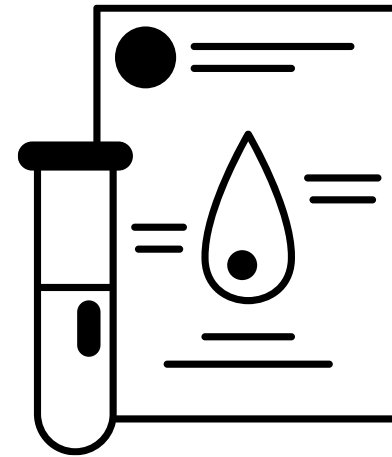


HIPAA Training April



*PF-3000 Authorization to Release
Medical Records*

&

PF-4000 Accounting of Disclosures



Authorization Requirement (9)

1. **Who will disclose** the information
2. **What information** can be disclosed
3. **Who will receive** the information
4. **The purpose(s) for disclosing** the information
5. **A statement that the authorization will expire:** (1) on a specific date, (2) after a specific amount of time (e.g., 5 years), **or (3) upon the occurrence of some event related to the patient**
6. The **signature of the patient and the date.** *Note: If the patient's personal representative signs the authorization, the authorization also must include a description of that person's authority to act for the patient.*
7. **A statement informing the patient** of (1) his or her **right to revoke the authorization** in writing, (2) how to revoke the authorization, and (3) any exceptions to the right to revoke
8. **A statement that the doctor cannot require** the patient to sign the authorization in order **to receive treatment or payment or to enroll or be eligible for benefits.**
9. **A statement that information disclosed** pursuant to the authorization **may be re-disclosed by the recipient and no longer protected** by the federal privacy regulations





Non-Compliant Forms

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name:	Date of Birth:
Address:	SSN:
City: <u>Hesperia</u>	Reason for Disclosure: <u>legal review</u>
State: <u>CA</u>	Recipient of Records Stratos Legal Records, LP 4299 San Felipe Suite 350 Houston, Texas 77027
Zip code: <u>92345</u>	
Telephone #:	

I, _____ (Patient full name) hereby authorize _____ (Name of medical care provider) to release and disclose all protected medical information from _____ (Dates of treatment) to _____ (Name of medical care provider) for the purpose of review and evaluation in connection with a legal claim.

I expressly request that the provider listed above disclose to the Recipient named above, full and complete protected medical information including any and all of the following:

- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires, histories, office and doctor notes, and records received by physicians.
- All autopsy, laboratory, histology, cytology, pathology, CT scans, PT scans, MRI, echocardiograms and cardiology reports.
- All original pathology blocks and/or slides.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CD's/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills and insurance records.

I understand that this information released may include treatment for physical and mental illness, alcohol/drug abuse, the presence of a communicable or non-communicable disease and/or HIV/AIDS test results and diagnostics. This consent is subject to revocation in writing at any time by mailing the revocation to the above named Recipient. Any revocation will not affect any uses and/or disclosures already made based on this authorization before the revocation is received by the Recipient. I understand that the information used and/or disclosed pursuant to this authorization may be redisclosed by the Recipient and may no longer be protected by the federal privacy law. I understand that my health care, payment for health care and eligibility for benefits or enrollment will not be affected by whether or not I voluntarily sign this authorization.

Any facsimile, copy or photocopy of this authorization shall authorize you to release the records and materials requested herein.

This authorization and consent will expire in one year from the date of authorization written below.



Signature of Patient/Parent or Legal Guardian: _____ Relationship if not Patient: _____
 Date Signed: 10/14/12

If signature is other than Patient or Patient's parent (if patient is under 18) a copy of the legal papers, verifying authority (i.e. estate administrator, appointed executor or power of attorney) must accompany this authorization when presented.

Release of Medical Information Form Revision 5/2011

Our Compliant Form




PF 3000
Doctor Name _____


Office Address _____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Do Not Use This Form If Records To Be Released Relate to HIV Test Results, Mental Health or Alcohol/Drug Abuse)

EXPLANATION: This Authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected health information ("PHI") about the patient identified below. Please provide all requested information. Failure to provide all requested information may prevent us from acting on this Authorization.

Name of Patient: _____ Date of Birth: _____

Other Names: _____ Account #: _____

1. PERSONS AUTHORIZED TO DISCLOSE PHI. I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section 2 below: *(State name of physician or specific identification of person or class of persons)* _____

2. DESCRIPTION OF INFORMATION. This Authorization permits the use and/or disclosure of the following information about patient: *(Check all applicable boxes and initial selection as required)*.

_____ (Initial) All my health information marked below pertaining to any medical history, physical condition and treatment received. Except *(optional)*: _____

Medical Office Records Hospital Records X-ray films & images Laboratory Results

Or, only the following records or types of health information and/or only on the specified date(s):
 Date(s) of Treatment: _____ Type of Treatment: _____

_____ (Initial) Other _____

3. AUTHORIZED USERS AND RECIPIENTS. I hereby authorize the following person or class of persons to receive and/or use the health information described in Section 2 above: *(State name and title if applicable.)* **Name:** _____ **Title (if applicable)** _____

Address: _____ City, State, Zip _____

4. PURPOSE. I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purposes: *(Check all applicable boxes)(Researchers should note that this must be research study specific, not for future unspecified research release)*

Requested by patient or personal representative. Other: _____

Physician or practice will be remunerated for this information. Yes No

5. RIGHT OF REVOCATION. I understand that I have the right to revoke this authorization at any time, providing that my revocation is in writing and conforms to requirements described in the ProHealth Partners/Argus Notice of Privacy Practices.

6. LIMITS TO REVOCATION. I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1 but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if patient (or personal representative) requested the Authorization, any revocation will be effective only when I communicate my revocation directly to them.

7. REDISCLOSURE. I understand that if the recipient of my information in Section 3 above is not a healthcare provider, a health plan or a health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.

8. CALIFORNIA RESTRICTIONS. I understand that a recipient of medical information in California may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. RIGHT TO REFUSE TO SIGN. I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment or benefits.

10. AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified.
 End date _____ Or Event _____

11. COPY RECEIVED. I acknowledge receipt of a signed copy of this authorization _____(Initials)

 Signature of Patient or Personal Representative Date _____

 Print name of Personal Representative (if applicable) Relationship of Personal Rep. to Patient _____

 Address Phone number _____

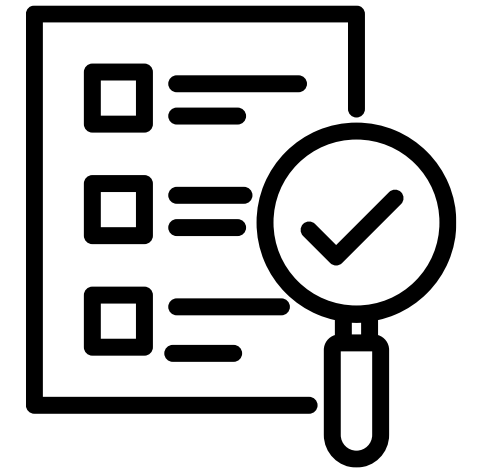
 Type of pt./rep. ID presented. Attach copy (optional) Verified Yes No Initials who verified _____

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE

Key Elements to a Compliant Form

1. Who is authorized to disclose the information: (Doctor name)

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



1. PERSONS AUTHORIZED TO DISCLOSE PHI. I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section 2 below: *(State name of physician or specific identification of person or class of persons)* _____

2. What exactly you are authorized to release:

Description of PHI to be used or disclosed (identifying the information in a specific and meaningful manner).

2. DESCRIPTION OF INFORMATION. This Authorization permits the use and/or disclosure of the following information about patient: *(Check all applicable boxes and initial selection as required)*.

_____ (Initial) All my health information marked below pertaining to any medical history, physical condition and treatment received. Except *(optional)*: _____

Medical Office Records Hospital Records X-ray films & images Laboratory Results

Or, only the following records or types of health information and/or only on the specified date(s):

Date(s) of Treatment: _____ Type of Treatment: _____

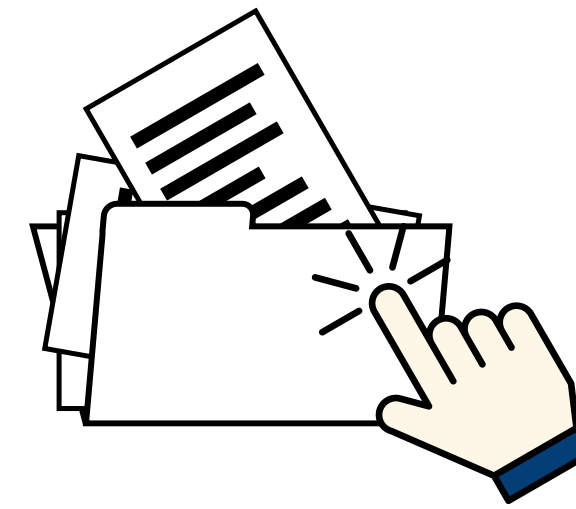
_____ (Initial) Other _____



MEDICAL MANAGEMENT, LLC

The Physician Practice Management Company®

3. Who we can give the information to:



- The name(s) or other specific identification of the person(s) or class of persons who may use the PHI or to whom the covered entity may make the requested disclosure.

3. AUTHORIZED USERS AND RECIPIENTS. I hereby authorize the following person or class of persons to receive and/or use the health information described in Section 2 above: *(State name and title if applicable.)* **Name:** _____ **Title** (if applicable)

Address: _____ City, State, Zip _____

4. Why patient wants information released:

- Description of each purpose of the requested use or disclosure. Researchers should note that this element must be research study specific, not for future unspecified research.

4. PURPOSE. I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purposes: *(Check all applicable boxes)(No authorization needed for research release)*

Requested by patient or personal representative. Other: _____

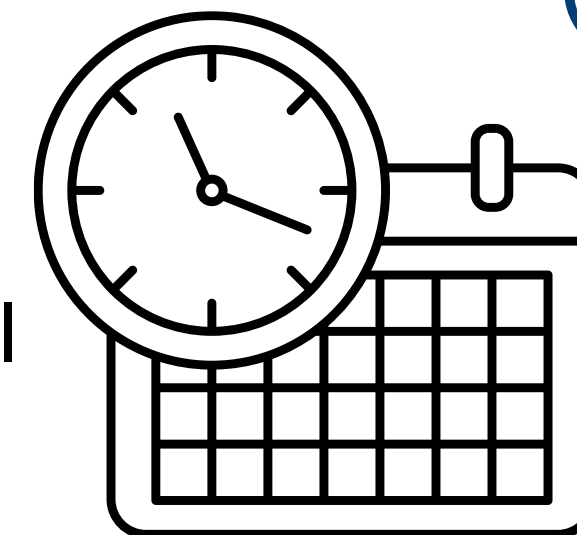
Physician or practice will be remunerated for this information. Yes No

5. Expiration Date of The Authorization

- Authorization expiration date or event that relates to the individual or to the purpose of the use or disclosure (the terms "end of the research study" or "none" may be used for research, including for the creation and maintenance of a research database or repository).

AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified.

End date _____ Or Event _____



6. Patient Signature and Date:



- Signature of the individual and date. If the Authorization is signed by an individual's personal representative, a description of the representative's authority to act for the individual.

Signature of Patient or Personal Representative

Date

Print name of Personal Representative (if applicable)

Relationship of Personal Rep. to Patient

Address

Phone number

Type of pt./rep. ID presented. Attach copy (optional)

Verified Yes No Initials who verified



7. Additionally, Must Include:

1. A statement of the individual's right to revoke the authorization, in writing, and either:
 - a. A reference to the revocation right and procedures described in the notice, or ...
 - b. A statement about the exceptions to the right to revoke, and a description of how the individual may revoke the authorization
2. A statement about the ability or inability of the covered entity to condition treatment, payment, enrollment, or eligibility for benefits on the authorization:



8. Information About Re-disclosure ⓘ

SEND YOUR HEALTH INFORMATION TO A THIRD PARTY



The infographic is titled "SEND YOUR HEALTH INFORMATION TO A THIRD PARTY" and is divided into three panels. The first panel shows a woman holding a key, with icons of a smartphone, a person, and a lock, representing that the patient holds the key to their information. The second panel shows a doctor at a desk with a tablet displaying a request from Hannah Brown, with a "MEDICAL RECORDS" sign, representing that the provider is no longer responsible for security after disclosure. The third panel shows a woman using a mobile app, with a magnifying glass over the app, representing the need for caution when using mobile applications.

You hold the key to your health information and can send or have it sent to anyone you want. Only send your health information to someone you trust.

Your provider is no longer responsible for the security of your health information after it is sent to a third party.

Be careful when sending your health information to a mobile application or other third party.

7. REDISCLOSURE. I understand that if the recipient of my information in Section 3 above is not a healthcare provider, a health plan or a health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.
8. CALIFORNIA RESTRICTIONS. I understand that a recipient of medical information in California may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

When the disclosure is not for

1. Treatment

2. Payment

3. Healthcare Operations

Examples:

- Attorney requests/subpoenas
- Life Insurance application
- Employment Physical



Doctor Name

Office Address



Form PF-4000

ACCOUNTING OF DISCLOSURES TRACKING SHEET

Use this form to track all disclosures outside of Treatment, Payment and Health Care Operations (TPO) for the Patient Listed Below. Our practice must keep and be prepared to make this information available to the patient, upon their request, for a period of six (6) years.

NAME OF PATIENT _____ DATE OF BIRTH _____

Date Information Was Released:	
To whom was the information (PHI) released/disclosed:	
Description of the information released/disclosed:	
Additional Information/Notes:	
Reported By:	Signature:

Date Information Was Released:	
To whom was the information (PHI) released/disclosed:	
Description of the information released/disclosed:	
Additional Information/Notes:	
Reported By:	Signature:

Date Information Was Released:	
To whom was the information (PHI) released/disclosed:	
Description of the information released/disclosed:	
Additional Information/Notes:	
Reported By:	Signature:

Just The Facts Please



NAME OF PATIENT _____

DATE OF BIRTH _____

Date Information Was Released:

To whom was the information (PHI) released/disclosed:

IMPORTANT!



Make sure to fill out the description and range of dates the medical records given.

Description of the information released/disclosed:	Examples: "Complete file", or "Progress notes only from dates Jan 2014 to April 2014"
Additional Information/Notes:	Example: "Gave black and white copies of color pictures of GI tests, not very clear"
Reported By:	Signature: