AUTHORIZATION FORM INSTRUCTIONS

This office requires a signed authorization from the patient or their personal representative. The authorization must follow the HIPAA Privacy Rule and this office's policy in the Privacy Plan[1]. 45 C.F.R. § 164.508.

REQUIREMENTS

- General content requirements for a valid authorization:

○ The name of the entity authorized to use & disclose the PHI. ○ A detailed description of the PHI to be used/disclosed. ○ An expiration date or event. ○ Whether the entity using/disclosing the PHI is receiving payment for the use/disclosure of the PHI directly or indirectly.	○ The name of the person or entity – or – the classes or categories of persons or entities receiving the PHI (naming the persons or entities is not mandatory)[2] ○ The reason/purpose for the use/disclosure. ○ Patient's rights related to the authorization. ○ See the policies listed below for exceptions, special requirements, and fees.

- An authorization cannot be accepted and invalid if any of the following are true:

○ The authorization is incomplete/missing information. ○ Required notifications or statements about patient rights are missing or incorrect. ○ You are aware that information on the authorization is false.	○ The expiration date has passed, or the expiration event has already happened. ○ You are aware that the patient has revoked the authorization.

- Retain the signed authorization, documentation of the patient's personal representative's authority, revocation, and any other related documentation (e.g., subpoenas, letters, etc. received with a signed authorization) for **6 years** after the latest date of any documentation or effective date of the authorization (e.g., the last disclosure made under the authorization or date of revocation).
- Refer to the following policies in the Privacy Plan for details about confirming authorizations received from others, requirements, and fees allowed.

○ Using and Disclosing PHI – Authorization Required ○ Fees for PHI Requests ○ Fundraising Communications ○ Research	○ Patient Request to Access Protected Health Information ○ Using and Disclosing Psychotherapy Notes ○ Marketing Communications

- The following types of authorizations require special attention that should be created with guidance before use. Contact TMC to help make sure these types of forms meet HIPAA requirements before use.
  - Compound Authorizations (two authorizations to use or disclose patient records combined into one document that are not for research – only valid in certain situations).
  - Authorizations for Research/Clinical Studies - including contributing PHI to a research database.

[1] Using and Disclosing PHI-Authorization Required policy

[2] https://www.hhs.gov/hipaa/for-professionals/faq/473/may-a-valid-authorization-list-categories-of-persons-who-may-use-protected-information/index.html

Complete if sending records to a physician or healthcare facility. (Page 1)

AUTHORIZATION TO RELEASE HEALTH INFORMATION

This form permits InStride Foot and Ankle Center of Durham (Name of Practice) to use and/or release the patient's health information for the purpose(s) described below.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ (mm/dd/yyyy) **Main Contact Number:** (___) _____ ☐ Home ☐ Cell ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

RECEIPIENT(S): This practice may use and/or release the information checked below to the following person or entity for the purpose(s) listed on this form.

Name: _____

Contact Person/Department: _____ Phone: (_____) _____

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

CHECK THE TYPE(S) OF INFORMATION TO BE USED AND/OR RELEASED:

☐ Entire record ☐ Billing/insurance records ☐ Office visit notes ☐ Psychotherapy Notes*

*If this request is for psychotherapy notes, any other records must be requested on a separate form. (No other boxes should be checked)

☐ Lab/diagnostic results related to: _____ (type) ☐ Records from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

☐ Records specific to a certain condition/treatment: _____

☐ Clinical images (e.g., X-ray)

☐ Other (describe): _____

Photos & Multimedia: ☐ Photo received from patient or personal representative

☐ Photo taken by staff (e.g., pre/post procedure) ☐ Other: _____

Post Photos/Images: ☐ In Office ☐ On website ☐ Other: _____

Do not include:

☐ Mental health records (Rx, diagnosis, etc.) ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

FORMAT/DELIVERY (if a release)

☐ Paper/mail ☐ Email: _____

☐ USB/CD-ROM ☐ Fax: (___) _____

☐ Secure Portal (name): _____ ☐ Other: _____

Requests for information to be released to third parties must be sent in a secure manner.

(Continued on back)

Complete if sending records to a physician or healthcare facility. (Page 2)

PURPOSE FOR THE USE OR RELEASE:

_____

_____

☐ This information will be used for marketing or fundraising activities. The practice/recipient will receive direct or indirect payment.

☐ This practice will receive direct or indirect payment that is more than the usual fee charged to prepare and release the information (e.g., a sale of PHI).

EXPIRATION DATE OR EVENT (not needed if this authorization was started by the patient)

☐ One-time use/release of information ☐ This information may be used/released until: _____
mm/dd/yyyy

☐ Release this information until the end of a treatment or other event (e.g., physical therapy): _____

_____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative.

_____ _____
Patient or Personal Representative Signature Date mm/dd/yyyy

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____
mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____
mm/dd/yyyy

Use/Release date(s): _____ ☐ Fee charged: _____
mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: _____

_____

Complete if medical records are being sent to you. (Page 1)

PATIENT ACCESS REQUEST

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ **Main Contact Number:** (___) _____
☐ Home ☐ Cell ☐ Work

Mailing Address: _____
(Street) (City) (State) (Zip)

REQUEST TYPE

☐ I would like a copy of my health information and I may be charged a reasonable cost-based fee.

☐ I would like a written summary/explanation of my health information. I understand a separate fee may apply.
☐ Provide in addition to a copy of my information ☐ Provide in place of a copy of my information

☐ I would like to review my health information on-site/in-office. I understand an appointment may be needed.
☐ I would like my healthcare provider to be present during the review. I understand an appointment and visit fee may apply.

RECORDS REQUESTED: ☐ Entire Record ☐ Other: _____

_____

FORMAT/DELIVERY – PATIENTS ONLY

☐ Paper ☐ USB/CD-ROM ☐ Fax: _____
☐ Mail ☐ Pick up at practice ☐ Patient Portal
☐ Email*: _____

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information after it is sent to you or others listed on this form.

REQUESTS – ELECTRONIC FORMAT & DELIVERY TO THIRD PARTIES

☐ I would like a copy of my *electronic* health information to be *electronically* transmitted to a third party.

Transmit to: _____
Name Phone Secure Email/Fax/EHR

RECORDS REQUESTED: ☐ Entire Record ☐ Other: _____
These records must be sent using a secure connection.

We will let you know about this access request within 30 days after it is received by this office. There are limited situations where your request may be denied. You will receive a letter explaining the reason for any denial. You can ask for a review/appeal of a denied request for certain situations.

_____ _____
Patient or Personal Representative Signature Date

Printed name and description of Personal Representative's Authority (e.g., healthcare power of attorney)

_____
(Attach documentation to support the personal representative's authority if not already on file with the practice)

Include if medical records are being sent to you. But, don't fill out. (Page 2)

FOR OFFICE USE & REFERENCE ONLY

Date Received: _____ (mm/dd/yyyy) By: _____ (Employee Name)

☐ Request Accepted ☐ Request denied (indicate reason below)

Date patient notified: _____ (mm/dd/yyyy) By: _____ (Employee Name)

Date information delivered as requested or agreed to by patient and this office to be sent in a different format than originally asked.

☐ Mailed: _____ (mm/dd/yyyy) ☐ Faxed: _____ (mm/dd/yyyy)

☐ Emailed: _____ (mm/dd/yyyy) ☐ Sent Securely ☐ Placed on patient portal: _____ (mm/dd/yyyy)

☐ EHR Direct technical standard: _____ (mm/dd/yyyy) ☐ Other: _____ (mm/dd/yyyy) (e.g., paper)

☐ Picked up in the office: _____ (mm/dd/yyyy)

More details of all approval, denial, and review/appeal rules are listed in the *Patient Requests to Access Protected Health Information* policy. The *Fees for PHI Requests* policy explains how to figure out allowable fees.

If denied, check the reason(s) here:

Reviewable denials - the healthcare provider has decided (by exercising professional judgement) that approving the request could cause one or more of the following dangers:

- ☐ Threaten the life or physical safety of the patient or another person.
- ☐ Cause significant harm to a someone mentioned in the PHI who is not a health care provider (e.g., family member, friend, coworker).
- ☐ The patient's personal representative made the request, and it is likely that approving the access request would cause substantial harm to the patient or someone else.

Unreviewable denials – reviews are not available for the following reasons:

- ☐ Psychotherapy notes.
- ☐ Information collected in reasonable expectation of, or for use in, a civil, criminal, or administrative action or proceeding.
- ☐ Information protected by the Clinical Laboratory Improvements Amendments of 1988.
- ☐ Information requested by an inmate of a correctional facility.
- ☐ Information created or obtained during research for as long as the research is in progress.
- ☐ Information that was given to the healthcare provider in confidence by someone who is not a healthcare provider. If the PHI is provided to the patient or their personal representative, that person's identity would be released with the information.

A copy of this office's complaint process and how to start a review/appeal (if applicable) should be sent with all denial letters.