	COUNTY OF SAN BERNARDINO STANDARD PRACTICE	NO.: 2-311 By: Gary McBride	ISSUE: 1 Page 1 of 2 EFFECTIVE: July 13, 2004
DEPARTMENT	PUBLIC HEALTH	APPROVED:	
SUBJECT	Information Security **AUTHORIZATION FOR RELEASE OF INFORMATION FORM**	JAMES A. FELTEN, MPA PUBLIC HEALTH DIRECTOR	

I. PURPOSE:

This Policy establishes an "official" Public Health Authorization for Release of Information Form that is compliant with both the Confidentiality of Medical Information Act (CMIA) and the Health Insurance Portability and Accountability Act (HIPAA).

II. POLICY:

Public Health Programs shall use the Authorization for Release of Information Form for requests for individually identifiable, or protected health information ***that is not an authorized disclosure or required by law***. This applies to requests initiated by:

- The client, his or her legal guardian, or personal representative
- Persons or organizations that are not part of the specific Program's workforce

III. SCOPE: This Policy applies to all divisions of the Department of Public Health (DPH).

IV. NEW FORM:

- Authorization for Release of Information (English) Form # 900.186.H13
- Authorization for Release of Information (Spanish) Form # 900.187.H13

V. OBSOLETE FORMS:

The new Authorization for Release of Information replaces and renders obsolete the English and Spanish versions of the following forms:

- Release of Medical Records Direct to Patient or Parent/Guardian Form # 900.005.H13
- Authorization For Release of Information From The Medical Record Form # 900.031.H13

VI. AMPLIFICATION:

This Policy applies to any "individually identifiable health information" (IIHI) or "protected health information," (PHI) related to an individual receiving services by Public Health.

IIHI or PHI is any information, including demographic information, whether in oral, electronic or written form that:

- Is created or received by a Public Health Program and
- Relates to the past, present or future physical or mental condition of an individual, or
- Relates to the past, present or future payment for the provision of health care to an individual.

IIHI or PHI:

- Identifies the individual or
- There is a reasonable basis to believe the information can be used to identify the individual.

IIHI or PHI includes any unique identifying numbers, codes or characteristics including, but not limited to the individual's:

Name	Fax #	Photographic Images	Medical Record #
Address	Cell Phone #	Vehicle or Device Serial #	Health Plan Beneficiary #
Birth Date	E-Mail	Names of Relatives	Account #
Social Security #	Finger or Voice Prints	Names of Employers	Certificate or License #
Telephone #			

VII. PROCEDURES:

A. Requesting Information

Public Health requests involving the use or disclosure of IIHI or PHI shall be made by means of the Authorization for Release of Information Form. The procedure requires:

1. Completing the Authorization for Release of Information Form.
2. Verifying the identity of the individual (client, parent, guardian, etc.) authorized to sign the form.
3. Verifying their authority of the individual (client, parent, guardian, etc.) to access the IIHI or PHI.
4. Obtaining the individual's signature.
5. Making 2 copies of the form.
   - Providing one copy to the individual for the client's records.
   - Placing one copy in the client's file for our records.
6. Sending or delivering the original to the person or organization to provide the information.

Note: Under no circumstances shall Public Health ask an individual to sign a blank Authorization form.

B. Providing Information

Public Health may provide IIHI or PHI to another person or organization pursuant to receipt of a valid Authorization for Release of Information Form. The procedure requires:

1. Determining if it is a valid Authorization Form. This is done by ensuring that it contains the following core elements and notification statements:

Core Elements	Notification Statements
• Name & organization - providing the PHI • Name & organization - receiving the PHI • Information to be used or disclosed • Purpose for each use or disclosure • An expiration date (not event) • Signature & date	• A right to revoke clause • Conditioning of treatment clause *Stating whether or not treatment, payment, enrollment or eligibility for benefits is conditioned on signing the Authorization and if so, what are the consequences.* • Subject to redisclosure clause *The person or organization receiving the information may no longer protect the information.* • Copy of the authorization clause *The individual will be provided a copy of the authorization.*

2. If the Authorization ***contains*** all of the required core elements and notification statements, Public Health may release the information.
3. If the Authorization ***does not contain*** all of the required core elements and notification statements, Public Health may not release the information. (Proceed to step C.)

C. Obtaining a Valid Authorization

Public Health may obtain a valid Authorization by sending the requesting party a copy of our Authorization for Release of Information and request they complete it and resubmit the request.

D. Minimum Necessary

Public Health shall limit the use or disclosure of IIHI or PHI to the minimum necessary to accomplish the intended purpose of the request.

E. Fee Requirement

If the Public Health Program requires a fee to cover staff time and costs related to processing an Authorization, the fee for service shall be entered on the second page of the Authorization for Release of Information.

County of San Bernardino
DEPARTMENT OF PUBLIC HEALTH

Authorization For Release of Information

Patient / Client Information			
LAST NAME:	FIRST NAME:	MIDDLE NAME:	D.O.B.:
ADDRESS:	CITY/STATE:	ZIP CODE :	MEDICAL RECORD /CASE #:

Person & Organization to Provide the Information
Name:
Organization:
Address:

Person & Organization to Receive the Information
Name:
Organization:
Address:

Information to be Released (Provide a detailed description of the specific information to be released)
1.
2.
3.

Purpose for Releasing the Information (Provide a detailed description of the activity for which the information will be used)
1.
2.
3.

This authorization will expire on: _____
Date (Not to exceed 365 days from date of signature on page 2)

Note **For clients requesting HIV antibody test results** HIV Antibody Test results can be released only one time per signed authorization request.

This request was fulfilled on by

County of San Bernardino
DEPARTMENT OF PUBLIC HEALTH

I understand that:

1. I am authorizing the use or disclosure of my health information as described on page 1 of this Authorization for Release of Information Form for the purpose(s) listed.

2. An additional authorization must be obtained for any other use or disclosure of health information or any portion of my medical record unless release is otherwise permitted or required by law.

3. I may refuse to sign this authorization. If I refuse to sign the authorization, it may adversely affect my eligibility for enrollment or benefits.

4. I have the right to cancel this authorization at any time, except to the extent that action has already been taken. Cancellation of this authorization must be in writing to the treating professional. Cancellation of this authorization may affect my right to further treatment or future treatment.

5. I will be provided a copy of this authorization after I sign it.

6. Information used or disclosed pursuant to the authorization could be subject to redisclosure by the requestor. If so, it may no longer be subject to state and federal law protecting its confidentiality.

Printed Name Signatory Person	Printed Name of Patient/Client, if different from Signatory Person
Signature	Date

If signed other than by patient/client, indicate relationship and authority to act for patient/client:

Relationship to patient/client	Authority to act for patient/client

Will the health plan or provider receive money for the release of this information?		
☐ Yes _____	_____	☐ No
	(Amount)	

Condado de San Bernardino
DEPARTAMENTO DE SALUD PUBLICA

Autorización Para Dar Información

Información del Paciente / Cliente			
APELLIDO:	**NOMBRE :**	**SEGUNDO NUMBRE:**	**FECHA DE NACIMIENTO:**
DIRECCION:	**CIUDAD/ESTADO:**	**ZONA POSTAL:**	**NUMERO DE CASO O EXPEDIENTE MEDICO:**

Persona y Organización a Dar la Información
NOMBRE:
Organización:
Dirección:

Persona y Organización A Recibir la Información
NOMBRE:
Organización:
Dirección:

Información a Dar (Provea detallada descripción de la información específica a ser proporcionada)
1.
2.
3.

Propósito de Dar la Información (Provea descripción detallada de la actividad para la cual la información será usada)
1.
2.
3.

Esta autorización caduca en: _____
Fecha (No debe exceder 365 dias de la fecha firmada en la pagina 2).

Nota **Para clientes que piden resultados de examenes de SIDA**

Los resultados de SIDA pueden ser proporcionados solamente una vez por autorización firmada

Esta autorización se completó en por

Condado de San Bernardino
DEPARTAMENTO DE SALUD PUBLICA

Yo entiendo que:

1. Estoy autorizando el uso o revelado de mi información de salud como descrito en la página 1 de esta Autorización para dar Información con el/los proposito (s) mencionados.
2. Una autorización adicional debe ser obtenida para cualquier otro uso o revelación de información de salud o cualquier otra parte de mi expediente medico a menos de que la revelación de información sea permitida o requerida por la ley.
3. Yo pudo negarme a firmar esta autorización. Si me niego a firmar esta autorización, esto puede afectar negativamente my elegibilidad a obtener servicios y beneficios.
4. Yo tengo derecho a cancelar esta autorización en cualquier momento, excepto por las acciones que ya hayan sido tomadas. Cancelación de esta autorización debe hacerse por escrito a la persona que esté proporcionando el tratamiento. Cancelación de esta autorización puede afectar mi derecho a continuar el tratamiento o futuros tratamientos.
5. Se me dará una copia de esta autorización después de que yo la firme.
6. Información usada o revelada de acuerto a la autorización puede ser sujeta a ser re-revelada por la persona que la requiere, y de ser asi, puede no ser protegida por leyes federales o estatales que protegen su confidencialidad.

Nombre impreso de la persona que la firma.	**Nombre impreso de el Paciente/Cliente, si es diferente de la persona que firma.**
Firma	**Fecha**

Si firmado por alguien mas que el paciente/cliente, indique la relación y autoridad para actuar por el paciente/cliente:

Relación con el paciente/cliente	**Autoridad para actuar por el paciente/cliente**

El plan de salud o proveedor recibiran dinero por dar esta información?	
☐ Si	☐ No

(Cantidad)