POLICY

It is the policy of the University of Pennsylvania Health System (UPHS) that protected health information (PHI) will be used and disclosed in a manner that respects a patient's right to privacy, and in accordance with HIPAA privacy regulations and applicable laws.

PURPOSE

The purpose of this policy is to define circumstances where a HIPAA authorization must be obtained to use or disclose PHI and what form and content that authorization must take.

SCOPE

This policy is applicable to all components and entities of UPHS including but not limited to: the Hospital of the University of Pennsylvania ((HUP); an unincorporated operating division of The Trustees of the University of Pennsylvania (Trustees)); Radnor Surgery Center, a facility of HUP; Presbyterian Medical Center of the University of Pennsylvania Health System d.b.a. Penn Presbyterian Medical Center (PPMC); the Penn Digestive and Liver Health Center University city (PDLH), a facility of PPMC; The Pennsylvania Hospital of the University of Pennsylvania Health System (PAH); Chester County Hospital; Chester County Health and Hospital System; Wissahickon Hospice d.b.a Penn Care at Home; Clinical Practices of the University of Pennsylvania (CPUP); Clinical Care Associates; Clinical Health Care Associates of New Jersey, P.C., the Hospital of the University of Pennsylvania Reproductive Surgical Facility; Lancaster General Health (LG Health), Lancaster General Hospital (LGH), and Lancaster General Hospital Ambulatory Surgical Facility (LGHASF); Princeton Health; the Surgery Center of Pennsylvania Hospital; the Endoscopy Center of Pennsylvania Hospital; the Surgery Center at Penn Medicine University City, a facility of Penn Presbyterian Medical Center; all ambulatory care facilities (ACF) that are off campus departments of PPMC operating in New Jersey, and all divisions, facilities and entities within UPHS that have a CMS Certification Number (CCN) or that are operating under the license of a UPHS entity (collectively the "Entities") excluding the Perelman School of Medicine (PSOM) except where specifically noted.

This policy applies to all disclosures of PHI with patient authorization.

IMPLEMENTATION

This policy will be implemented by the Privacy Office and by those who disclose PHI with patient authorization.

DEFINITIONS

Disclosure means the release, transfer, provisions of access to, divulging in any other manner of information outside UPHS.

Protected Health Information (PHI) is information that is created or received by UPHS and relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient; and that identifies the patient or for which there is a reasonable basis to believe the information can be used to identify the patient. PHI includes information of persons living or deceased. The following components of a patient's information also are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates

directly related to a patient, including birth date, admission date, discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

Psychotherapy Notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical records. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Use means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within UPHS.

PROCEDURE

REQUIRED FORMS

The HIPAA privacy regulations create standards for how authorizations must be written and the information they must contain. The Authorization Form that an individual signs must be written in plain English and contain certain required elements. The Authorization For Disclosure of Health Information ("Authorization Form") contains those required elements, and may not be altered without the approval of the UPHS Privacy Office and/or the Office of General Counsel (see example attached – note that only official forms should be used.

An authorization form originating outside UPHS or PSOM may be accepted provided it contains every item of information listed on the attached Authorization Form.

OBTAINING AUTHORIZATION

A patient's authorization must be obtained prior to using or disclosing PHI unless the PHI is being used or disclosed for:

- Treatment, payment, or healthcare operations (see policy entitled "Uses and Disclosures for Treatment, Payment, or Health Care Operations")
- Purposes not requiring patient permission (see policy entitled "Disclosures Where No Form of Patient Permission is Required")

AUTHORIZATION REQUIRED FOR MENTAL HEALTH, SUBSTANCE ABUSE, AND HIV-RELATED RECORDS

Patients who wish to authorize the release of their mental health, substance abuse or HIV-related records must specifically authorize the release of these classes of information on the Authorization Form. These classes of information are subject to special Disclosure requirements under state law. Such information may also be disclosed pursuant to a court order explicitly authorizing release of information or as otherwise permitted under applicable law. A statement warning against re-Disclosure must accompany the record copy.

SALE OF PHI

All Disclosures of PHI where UPHS directly or indirectly receives remuneration from or on behalf of the recipient of the PHI, in exchange for the PHI, requires patient authorization. (See policy entitled "Prohibition on the Sale of PHI")

MARKETING

All uses and Disclosures of patient's PHI for all communications that are marketing, require patient authorization. If the marketing involves direct or indirect remuneration to UPHS from a third party, the authorization must state that such remuneration was received. (See policy entitled "Marketing and Other Related Health Care Communications")

SPECIAL PROVISIONS FOR PSYCHOTHERAPY NOTES

Further, patient authorization is required for any use or Disclosure of psychotherapy notes, except to carry out the following treatment, payment, or healthcare operations:

- Use by the originator of the notes for treatment;
- Use or Disclosure by UPHS in training programs in which students, trainees or practitioners in mental health learn under supervision to practice or improve their skills in counseling;
- Use or Disclosure by UPHS to defend a legal action or other proceeding brought by the patient;
- Uses or Disclosures to the subject of the psychotherapy notes;
- Uses or Disclosures required by law;
- Uses or Disclosures for health oversight activities with respect to the originator of the notes;
- Uses or Disclosures about decedents to coroners and medical examiners; and
- Uses or Disclosures to avert a serious threat to health or safety.

A standard subpoena is generally insufficient to authorize release of this information.

PROHIBITION ON REQUIRING AN AUTHORIZATION IN ORDER TO PROVIDE TREATMENT

UPHS may not condition treatment on the provision of an authorization, with the exception of treatment that is also research requiring the patient's informed consent.

REVOCATION OF AUTHORIZATION AND CONSENT TO RELEASE

An individual may revoke in writing, an authorization or consent to release, at any time, except to the extent that UPHS has taken action in reliance on the authorization or consent to release.

STATE LAW

If the laws of the state(s) in which the applicable UPHS entity operates have more stringent requirements than those set forth in this policy, UPHS will comply with the most restrictive applicable law, statute, or regulation.

SUPERSEDES:	ISSUED BY: Lauren Steinfeld Lauren B. Steinfeld Assistant Vice President, Audit Compliance and Privacy Chief Privacy Officer, Penn Medicine University of Pennsylvania Health System

Penn Medicine

Label Area

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (First, Middle, Last)		Date of Birth
Address	City/State/Zip Code	Telephone Number

I am requesting my protected health information (PHI) from ☐ All Penn Medicine Locations

☐ Hospital of the University of Pennsylvania ☐ Penn Presbyterian Medical Center ☐ Pennsylvania Hospital ☐ Penn Medicine at Home

☐ Chester County Hospital ☐ Lancaster General Health ☐ Penn Medicine Princeton Health

☐ CPUP/CCA Outpatient Practice(s) _____ ☐ Other _____

I request my PHI to be released to:

Name of Person/Entity: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Covering the period(s) of care (list applicable dates of treatment): _____ / _____ / _____ **to** _____ / _____ / _____

I authorize the following PHI to be released from my medical records:

☐ Discharge Summary ☐ Operative Report ☐ Lab Reports ☐ Radiology Reports ☐ Radiology Images

☐ Discharge Instructions ☐ ER Record ☐ EKG/ECG/Cardiac Tests ☐ History and Physical ☐ Clinic/Progress Notes

☐ Itemized Billing Record ☐ Consultations ☐ Medication Records ☐ Abstract (Significant Documents)

☐ Other Instructions: _____

Behavioral Health Visits.

I authorize the release of information from my behavioral health visits by checking "Yes" here and signing below: ☐ Yes ☐ No

Substance Use Disorder (SUD) Visits.

I authorize the release of information from my SUD visits by checking "Yes" here and signing below: ☐ Yes ☐ No

Other than the behavioral health and SUD visit information described above, I understand that **the records I have selected to be released may contain information about treatment and testing regarding genetics, behavioral health, HIV/AIDS, and substance use disorder** (for example, from primary care visits) and that by signing this authorization I am agreeing to the release of such information. I can choose and have the right to have my records released directly to me so that I can review and inspect the materials, including for sensitive information I do not wish to be disclosed to a third party.

Purpose of requesting information:

☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care ☐ Other: _____

Delivery Method:

☐ **US Mail (Paper)** ☐ **CD** ☐ **Fax** ☐ **Email, file size limits apply, if requested please provide email address:** _____

Important: CD/discs of images are not encrypted and may be accessible to others. Email generally is not secure and often is misdirected. I am accepting these risks.

AUTHORIZATION

My authorization will automatically expire one hundred eighty (180) days after the date of signature. I may revoke this authorization at any time, but must do so in writing, and the revocation will not apply to information that has already been released. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing Penn Medicine to release information as described above.

Signature of Patient or Personal Representative	Print Name	Date	Time
Relationship of Personal Representative to Patient	Print Name	Date	Time

If Authorization is signed by someone other than the patient, please state reason: _____

If information about behavioral health visits is being released as authorized above, signature of hospital representative validating authorization required.

Signature of Hospital Representative	Print Name	Date	Time
Signature of Second Witness for Verbal Consent	Print Name	Date	Time

Instructions for Completing the Authorization for Disclosure of Health Information

1. Please carefully read and complete all sections of the Authorization for Disclosure of Health Information.
2. The patient or legally authorized representative must sign and date the form. Generally, only a patient may authorize release of his/her medical information.

   Exceptions to the rule are as follows:

   a. Authorization of minors – If the patient is a minor (under 18 years of age), the authorization must be signed by a parent or legal guardian.
   b. Emancipated minors – An emancipated minor is a minor who is or has been married, is or has been pregnant or who is a high school graduate. Emancipated minors can authorize the release of their medical information.
   c. A minor who has been diagnosed with a venereal disease, a substance use problem or was treated to determine pregnancy may consent to treatment of that disease or condition and may authorize release of any medical information related to that disease or condition.
   d. Authorization after death – An authorization must be signed by decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains can authorize the release of medical information.
   e. Authorization of the incompetent patient – If the patient is deemed incompetent, then the patient's legally authorized representative must sign the authorization for release of information.
   f. Signature of Staff – The staff obtaining signature requirement applies only to the release of behavioral health care information as specifically authorized by the patient. The hospital or records management staff person obtaining this authorization of the patient or legally authorized representative (either in writing as witnessed, or by verbal confirmation of the written form) should sign, print name, date and time the form. A second witness is required to sign if the patient/patient representative consents verbally. Please have the witness sign, print their name and include the date and time.

Penn Medicine reserves the right to request proof of representation.

Any Ambulatory/Office Visit requests should be addressed to the individual Physician's Office.

The address to submit Inpatient, Emergency Department and Ambulatory Procedure/Short Procedure Unit record requests:

Hospital of the University of Pennsylvania (HUP)
3400 Spruce Street
Medical Records Department
1st Floor Founders
Philadelphia, PA 19104

Penn Presbyterian Medical Center (PPMC)
51 North 39th Street
Medical Records Department
Myrin Basement
Philadelphia, PA 19104

Pennsylvania Hospital (PAH)
800 Spruce Street
Medical Records Department
1st Floor Preston
Philadelphia, PA 19107

Chester County Hospital (CCH)
701 East Marshall Street
Medical Records Department
West Chester, PA 19380

Lancaster General Health (LGH)
555 N. Duke Street, 1st Floor
Medical Records Department
Lancaster, PA 17604

Penn Medicine Princeton Health (PMPH
One Plainsboro Road
Medical Records Department
Plainsboro, NJ 08536

Please note:

1. Penn Medicine will charge for copying records in accordance with Pennsylvania, New Jersey and Delaware law, as applicable. Patient cost for Radiology images and reports will be free of charge.
2. Penn Medicine will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.
3. Penn Medicine will make reasonable efforts to comply with this request within thirty (30) days for information that is maintained or accessible on site and within sixty (60) days for information that is not maintained on site. If Penn Medicine is unable to comply with this request within the specified time periods, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.
4. Penn Medicine may deny this request under limited circumstances as provided for under federal law. Penn Medicine will notify you if it denies your request to access or obtain a copy of the requested information. If Penn Medicine denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional. To request such a review, please contact the Penn Medicine Chief Privacy Officer at the following address: Office of Audit, Compliance and Privacy, 3819 Chestnut Street, Suite 214, Philadelphia, PA 19104.
5. Records released may contain information and images created and prepared by third parties not under the control of Penn Medicine. Penn Medicine is not responsible for the content, accuracy or review of such records.
6. **Recipients of mental health or HIV/AIDS information may not re-disclose that information unless with written patient consent or as allowed by law. Federal regulation 42 CFR Part 2 prohibits unauthorized disclosure of substance use disorder records.**