

# The HIPAA Privacy Rule: THREE KEY FORMS

Complying with the HIPAA privacy rule may seem trickier than pulling a rabbit out of a hat, but these forms should help.

Jennifer Bush

**D**on't expect another delay. The privacy component of the Health Insurance Portability and Accountability Act (HIPAA) will take effect on April 14, 2003, and by then, your practice should have made a good-faith attempt to be ready. HIPAA requires, among other things, that you safeguard patients' individually identifiable information (also referred to as protected health information or PHI) by restricting access to it and seeking patient permission to disclose it in certain circumstances. Some (but not all) of the safeguards can be established with the forms that appear on the following pages.

## Notice of privacy practices

HIPAA legislation grants patients several new rights, among them greater access to and control over their medical records. (To learn more about HIPAA, see "The HIPAA Privacy Rule: Answers to Frequently Asked Questions," *FPM*, November/December 2002, page 35 and the box on page 30.) Organizations considered covered entities under HIPAA are mandated to inform patients of the new privacy rights and their privacy policies and procedures (to determine whether you're a covered entity, go to [www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp](http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp)).

To comply, you'll need to develop a Notice of Privacy Practices and provide it to your patients at the first office visit after April 14, 2003 (or earlier, if you have it ready). HIPAA also requires you to obtain patients' written acknowledgement that notice has been received and file the

acknowledgement in the patient record. A patient's refusal to sign the acknowledgement should be documented and filed in the patient record. A sample Notice of Privacy Practices appears on page 32. It is intended as a guideline only and should be tailored to reflect your practice policies and your state's privacy laws. State privacy laws should continue to be followed if they are more stringent than the HIPAA regulations. ►

*Jennifer Bush is a senior associate editor for Family Practice Management. Conflicts of interest: none reported.*

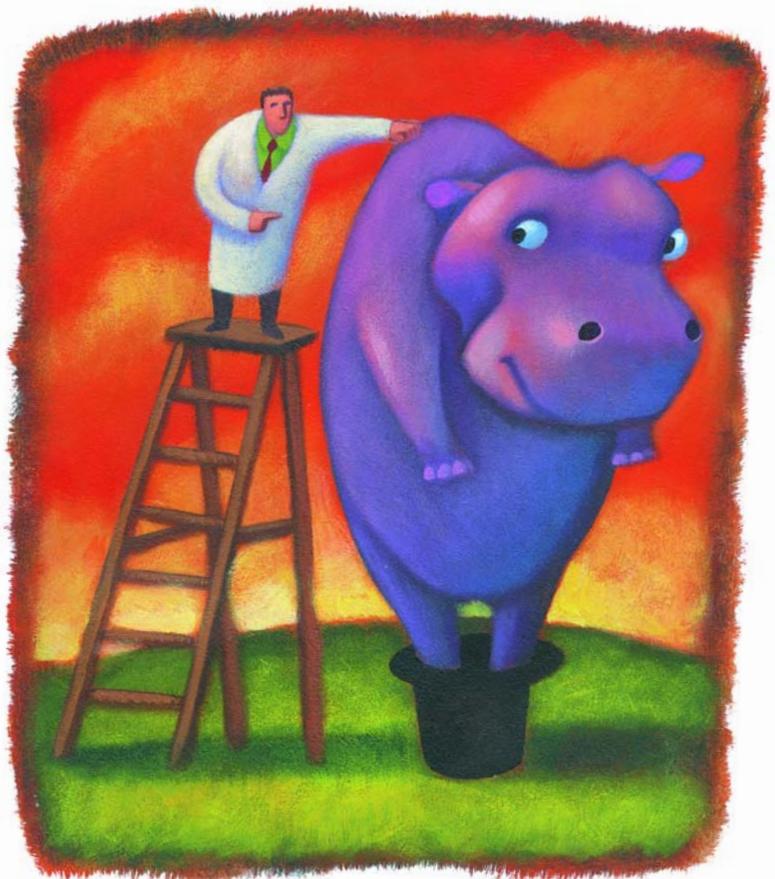


ILLUSTRATION BY WILL TERRY

## Authorization form

Fortunately, the HIPAA privacy regulations do not require you to obtain patients' consent to use their PHI for routine disclosures, such as those related to treatment, payment or health care operations (TPO). However, the regulations do mandate that you obtain written patient consent before releasing their information for any reason other than TPO (e.g., disclosure of psychotherapy notes). To comply, you'll need to identify situations in your practice where special

authorization is needed (see page 31 for a list) and develop an authorization form for patients to sign. The sample authorization form below can be adapted for use in your practice. A signed copy or documentation of the patient's refusal to sign should be retained in the patient record.

## Patient consent form

Although not specifically required by HIPAA, you may also want to consider using a Patient Consent Form in your practice (see page 31). A consent form specifies methods by which a patient agrees to let your practice use his or her protected information for routine TPO purposes. Should a patient complain that his or her privacy rights have been violated, a consent form may afford you an extra measure of protection if your practice is investigated for HIPAA noncompliance.

## Don't delay

The forms provided here represent only a few of the new administrative measures HIPAA will require. There are

### HIPAA RESOURCES

To learn more about HIPAA, visit:

American Academy of Family Physicians ([www.aafp.org/hipaa](http://www.aafp.org/hipaa))

American Medical Association

([www.ama-assn.org/ama/pub/category/4234.html](http://www.ama-assn.org/ama/pub/category/4234.html))

Department of Health and Human Services ([www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa))

## AUTHORIZATION FORM



**Your Practice Name**

### Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **insert name of practice** to use and/or disclose certain protected health information (PHI) about me to \_\_\_\_\_.

This authorization permits **insert name of practice** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

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The information will be used or disclosed for the following purpose:

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(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on **(enter date or defined event)**

The practice  will  will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **insert practice name**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

**Insert name and address of practice**

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian Date Relationship to Patient

Print Patient's Name

Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

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*Note: This document is a template only. It does not reflect the requirements of your state's laws. You should consult with advisors (e.g., your state or local medical or specialty society, or legal or other counsel) familiar with your state's privacy laws prior to using this document.*

other forms, (e.g., a business associate agreement) and more work to do by April 14, 2003. If you need help, both the AMA and the AAFP offer affordable, step-by-step guides to implementing the privacy rule (see [www.ama-assn.org/ama/pub/category/8910.html](http://www.ama-assn.org/ama/pub/category/8910.html) or [www.aafp.org/hipaa](http://www.aafp.org/hipaa) for more information).

Don't delay, but don't panic either. The government realizes that full compliance takes time. Perfection isn't expected, but a reasonable effort to comply is. You still have about 90 days. Granted, it's not much time, but it's enough to get you where you need to go.

*Editor's note:* The forms provided in this article are available for you to download and customize at [www.aafp.org/fpm/20030200/29th.html](http://www.aafp.org/fpm/20030200/29th.html). They have been adapted from the AAFP's *Health Insurance Portability and Accountability Act (HIPAA) Privacy Manual: A How-To Guide for Your Medical Practice*. Available at [www.aafp.org/hipaa/manual](http://www.aafp.org/hipaa/manual). 

## SITUATIONS REQUIRING PATIENT AUTHORIZATION

Under the HIPAA privacy rule, your practice must obtain patient authorization to use patients' protected health information (PHI) for reasons other than routine treatment, payment or health care operations, including:

- To disclose PHI about a patient to a third party (i.e., a life insurance underwriter);
- To market products or services except if the marketing communication is face-to-face with the patient or it involves the provision of services of nominal value;
- To raise funds for any entity other than your practice;
- To conduct research, unless your practice has signed a waiver approved by the Institutional Review Board for the use and disclosure of PHI or has de-identified PHI;
- To disclose psychotherapy notes, unless disclosure is required for law enforcement purposes or legal mandates, oversight of the provider who created the notes, use by a coroner or medical examiner, or avoidance of a serious and imminent threat to health or safety.

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## PATIENT CONSENT FORM



Use of this form is optional and not required under the HIPAA privacy rule.

**Your Practice Name**

### Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **insert name of practice** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **insert name of practice** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **insert name of practice** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **insert name and address of privacy officer for the practice**.

With this consent, **insert name of practice** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **insert name of practice** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **insert name of practice** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **insert name of practice** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **insert name of practice** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **insert name of practice** may decline to provide treatment to me.

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date Relationship to Patient

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

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# NOTICE OF PRIVACY PRACTICES

Effective date: \_\_\_\_\_

**Your Practice Name**

## Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

### A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

### B. If you have questions about this Notice, please contact:

Insert name or title, address and telephone number of a person or office to contact for further information

### C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

- 1. Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
- 2. Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
- 3. Health care operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

**4. Optional: Appointment reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.

**5. Optional: Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

**6. Optional: Health-related benefits and services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

**7. Optional: Release of information to family/friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

**8. Disclosures required by law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

### D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- 1. Public health risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
  - Maintaining vital records, such as births and deaths,
  - Reporting child abuse or neglect,
  - Preventing or controlling disease, injury or disability,
  - Notifying a person regarding potential exposure to a communicable disease,
  - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
  - Reporting reactions to drugs or problems with products or devices,
  - Notifying individuals if a product or device they may be using has been recalled,
  - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
  - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- 2. Health oversight activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- 3. Lawsuits and similar proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- 4. Law enforcement.** We may release PHI if asked to do so by a law enforcement official:
  - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
  - Concerning a death we believe has resulted from criminal conduct,
  - Regarding criminal conduct at our offices,
  - In response to a warrant, summons, court order, subpoena or similar legal process,

- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. **Optional: Deceased patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Optional: Organ and tissue donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Optional: Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. **Serious threats to health or safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' compensation.** Our practice may release your PHI for workers' compensation and similar programs.

#### E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **insert name or title and telephone number of a person or office to contact for further information** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **insert name or title and telephone number of a**

**person or office to contact for further information.** Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. **Inspection and copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **insert name or title and telephone number of a person or office to contact for further information** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **insert name or title and telephone number of a person or office to contact for further information.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **insert name or title, and telephone number of a person or office to contact for further information.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **insert name or title and telephone number of a person or office to contact for further information.**

7. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **insert name or title and telephone number of the contact person or office responsible for handling complaints.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* We are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **insert name or title and telephone number of a person or office to contact for further information.**

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