HIPAA AUTHORIZATION FOR USE AND DISCLOSURE

BY SIGNING THIS FORM, YOU PERMIT THE HEALTH CARE PROVIDER(S)/HEALTH PLAN(S) IDENTIFIED BELOW TO DISCLOSE YOUR CONFIDENTIAL PERSONAL HEALTH INFORMATION

1. **PATIENT/INSURED**. The patient/insured whose information may be released is:

NAME _____ **D.O.B.** _____
ADDRESS _____
PHONE # _____ **ACCOUNT OR POLICY # (if known)** _____

2. **PERSONAL HEALTH INFORMATION**. Disclose the following documents or dates of service (be specific) _____
_____

OR

If Provider:
☐ Discharge summary - ☐ Face sheet
☐ H&P/consultation - ☐ Progress notes
☐ ER record - ☐ Operative report
☐ X-rays and other films - ☐ Lab results
☐ Itemized statement - ☐ Billing records
☐ Entire medical record

If Health Plan:
☐ My enrollment/application record
☐ My premium payment/billing record
☐ My claims record (claim #: _____)
☐ My medical record

3. **SPECIAL LIMITATIONS**. Does this Authorization exclude (check all that apply):

☐ HIV/AIDS test results (if part of the specified record)
☐ Other exclusions (be specific) _____
_____

4. **DISCLOSING PROVIDER/PLAN**. The following provider(s)/plan(s) may *disclose* the personal health information:

Provider/Plan _____
Address _____ Phone _____

5. **RECIPIENT**. The following persons or organizations are to *receive* the personal health information:

Name _____ Phone _____
Address _____

6. **PURPOSE OF DISCLOSURE**. The reason I am authorizing release is:

☐ My request ☐ Other (describe): _____

7. **EXPIRATION**. This Authorization expires (periods longer than 180 days may not be accepted):

Date: _____ ***OR*** Event: _____

8. **EXPLANATION OF RIGHTS**. I understand that:

- I can revoke this Authorization at any time by giving my written revocation to **the Disclosing Provider/Plan**. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.
- The disclosing provider/plan may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this Authorization.
- I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.

_____ _____
Signature of Patient/Insured or Personal Representative Date

_____ _____
Representative's Relationship to Patient/Insured (if applicable) Representative's Printed Name

Use of this form does not assure acceptance by provider or health plan. This form is not to be interpreted as the standard HIPAA authorization for Nebraska. (*See "Explanation and Instructions" on reverse side*)

EXPLANATION AND INSTRUCTIONS

1. ***Explanation***. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. §§ 1320d to d-7, and the privacy regulations issued thereunder at 45 C.F.R. §§ 160.101 *et seq*. and 164.501 *et seq*. impose many new privacy duties on covered health care providers (doctors, hospitals, nursing homes, pharmacies, physical therapists, etc.) and health plans (typically insurers and group health plans offering health, dental, vision, Medicare supplemental and long-term care coverage). Under HIPAA, before a covered provider/plan may disclose protected health information based on a patient's/insured's authorization or the authorization of a "personal representative," *the authorization form itself must meet specific (often new) content requirements.* Specifically, see 45 C.F.R. § 164.508, the rule governing required content of authorizations.

The purpose of this form is to give lawyers and others a standard form which covered health care providers and plans in Nebraska should accept. Note that if you are dealing with a specific provider or plan, you can always obtain and use their pre-printed form and thereby be assured they will not object to the form of the authorization. Use this form to: (i) to obtain protected health information (a medical record or a health care billing record, for example) from a provider or plan, or (ii) to help a patient/insured or their personal representative arrange for disclosure of protected health information to a third party.

2. ***Description of Information to be Released***. HIPAA requires authorizations to identify the information to be released "*in a specific and meaningful fashion*." Providers/Plans will not honor authorizations if the scope of covered information is unclear. In various guidance, the regulators approve of descriptions such as "entire medical record" or "complete patient file" because they put the patient or personal representative on notice of what information is covered. Elsewhere, the guidance suggests a description such as "all protected health information" might not be sufficiently specific and meaningful to permit disclosure of a medical record. Be as specific as possible. It is recommended that you identify the treating MD or practitioner and the specific clinic or facility at which services were received, if known, when requesting a specific record to facilitate locating the correct record and information. *An authorization to release "psychotherapy notes" cannot be combined with another authorization*.

3. ***Disclosing Provider/Plan and Recipients***. HIPAA requires the authorization to include "*the name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure*." An authorization can name one or more specific providers or plans, or it can identify disclosing providers or plans by class, such as "any physician, health care professional, hospital, clinic, laboratory . . . , or other health care provider that has provided treatment or services to me or on my behalf."

Recipients can also be identified specifically or by class. However, do not describe a class of recipients, if it will leave the disclosing provider/plan guessing. For example, identify the recipient as "the XYZ Law Firm and any of its attorneys" (easily identifiable and verifiable) rather than "any lawyer providing legal services to me." The provider/plan is left having to contact the patient/insured to verify your representation in this latter case.

4. ***Purpose***. HIPAA only requires that an authorization state a purpose if the authorization is being requested or initiated by the covered entity holding the information (for example, a hospital requesting an authorization so it can use information for research purposes). Check "my request" if the patient/insured is initiating the authorization.

5. ***Expiration Date or Event***. An authorization must state an expiration date or event. If an authorization "event" is used, it *must be an event that relates to the individual or the purpose of the use or disclosure*. Guidance suggests expiration events such as "upon termination of enrollment in a health plan" would be a sufficient description of an expiration event. You may also be able to use "conclusion of [named] litigation" as an expiration event. If you use an expiration event, be sure it is something the disclosing provider/plan will know about. See also Neb. Rev. Stat. § 71-8403(1) which many providers/plans interpret as placing a maximum time limit of 180 days on any authorizations.

6. ***Personal Representatives***. The authorization must be signed by the patient/insured or their "personal representative." A personal representative is someone who, *under state law*, has "authority to act on behalf of an individual who is an adult or an unemancipated minor in making decisions related to health care." Obvious examples in Nebraska are persons named as decision makers in a health care power of attorney, court-appointed guardians, court-appointed conservators as to information needed to carry out their responsibilities, parents of unemancipated minors (in most situations), and spouses and adult children of incapacitated patients/insureds. In the case of deceased patients/insureds, court-appointed personal representatives are usually required.