ONE BRAIN & SPINE CENTER℠

ORTHOPAEDIC SURGERY | NEUROSURGERY | EXCELLENCE
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To customize this template document, replace all of the text that is presented in brackets (i.e. "[" and "]") with text that is appropriate to your organization and circumstances. After completing the customization of this document, the document should be reviewed by an attorney who is familiar with health privacy laws and regulations in the state(s) in which the organization maintains its offices or facilities, and who is in a position to provide legal counsel to your organization. ***Please note that new California state laws require that this authorization be in 14 point type font.***

Note on Marketing: HIPAA established special requirements for marketing activities. The patient's authorization must be obtained for all marketing activities except:

1. face-to-face communication by the physician or other employee of the physician practice; or
2. promotional gifts of nominal value provided to the patient by the physician practice.

In addition, the authorization must indicate whether the physician practice receives direct or indirect remuneration from a third party in connection with the marketing activities.

Thus, to the extent the authorization concerns marketing activities, the following should be added to the form:

> **Marketing**
>
> This authorization authorizes marketing activities for which this medical practice ❑ will ❑ will not receive direct or indirect compensation.

"Marketing" is defined by HIPAA to include all communications that encourage the purchase or use of a product or service except communications for:

1. treatment;
2. case management or care coordination of the individual, or direct or to recommended alternative treatments, therapies, health care providers or settings of care; or
3. certain other health plan communications concerning benefits.

***** *For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released. Under HIPAA, an authorization for release of psychotherapy notes may not be combined with an authorization involving any other type of health information (except other psychotherapy notes).*

******** *It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

[Physician Practice Name and Address]

[Name, Title and Telephone Number of Privacy Officer]

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning

_____

(*patient name and address*) as follows:

Health information to be used or disclosed (check *only* one box):*

- ❑ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below: _____

_____

_____

- ❑ All psychotherapy notes may be released, except as specifically provided below: _____

_____

_____

This health information may be disclosed to:

_____

(*Name and address of person to use or receive the health information*)

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual": _____

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Effect of Refusal to Sign Authorization [Note: Physician Practice must include one of the following, as appropriate:]

[I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.] ***or***

[I understand that if I do not sign this form:]

[I cannot participate in this research-related treatment.]

[A health plan may not enroll me or make me eligible for benefits.]

[My physician will not perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.]

This authorization is effective now and will remain in effect until _____
(*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.

Signed:_____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- ❑ parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient ******
- ❑ spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

*****Signed: _____ Dated: _____
Treating Physician

Authorization Tracking Information

Name of Patient:

_____

Address:

_____

_____

For Office Use Only:

Date received:	Processed by:
Review Date:	Response Date:
Patient Follow-up: ❑ Yes ❑ No	Date of Patient Follow-up:
Practice Follow-up: ❑ Yes ❑ No	Date of Practice Follow-up:

Reviewer's Comments:

Action Taken: