

Sample Forms

- Authorizations
- Business Associate Agreement (BAA)
- Women's Health and Cancer Rights Act (Janet's Law)

Authorization Details

A group health plan and its business associates must obtain the patient's written authorization for uses other than those noted in "When Authorization is Not Needed" below.

An authorization is a specific, time-limited document. A sample authorization is provided in this packet. The authorization form must be in plain language and include the following elements:

- A description of the information to be used or disclosed;
- Identity of the persons or class of persons authorized to make, and to whom authorized to make, the uses and disclosures;
- Description of each purpose of the use or disclosure (for and individual's request, this is not necessary);
- Specific expiration date of the authorization;
- The individual's signature and date;
- If signed by the patient's personal representative, a statement of the representatives authority to act on behalf of the individual;
- Statement that the individual may revoke the authorization in writing and either a statement of the individual's right to revoke and instruction on how to do it, or a reference to the covered entity's notice of privacy practices.
- Statement that treatment, payment or other benefits may not be conditioned on the authorization, whether or not the authorization applies under the Privacy Rule, and the consequences of refusing to sign the authorization.
- Statement that the recipient may redisclose PHI.

Note: Plans using and disclosing PHI based on authorizations are not required to provide an accounting of those transactions made during the preceding six years.

When the covered entity requests the individual's authorization for the entities own use or disclosure of protected health information that the covered entity itself maintains, a copy of the authorization must be given to the individual.

Before an individual enrolls in a plan, the plan may require the individual's authorization for the use or disclosure to the health plan of PHI (except psychotherapy notes) for eligibility for benefits and enrollment in the health plan of an individual or for the plan's underwriting or risk-rating determinations.

When an Authorization is Not Needed

A self-funded plan does not need participant authorization when protected health information is used for the following treatment, payment and operations purposes (also known as TPO):

- Treatment, which includes the provision, coordination, and management of health care.
- Payment, which includes the premium payments, contributions, benefits, and cost sharing amounts, determinations of eligibility and coverage, utilization review, coordination of benefits, subrogation, and activities related to reimbursement through reinsurance.
- Health care operations, which include quality assessments, certain health improvement activities, underwriting or premium rating for contract renewals, performance or arrangement of audits and legal services, various business planning and management activities, aggregating and analyzing PHI, resolution of initial grievances, and due diligence in corporate transactions.

Examples of aggregating and analyzing PHI include the following, according to the regulations:

Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives.

- Public policy purposes generally related to public health concerns and law enforcement activities.
- Individuals' requests for access to their own PHI.
- HHS investigations of compliance with the privacy rules.

The preamble to the final rule clarifies that if a covered entity is permitted to share PHI with another covered entity, the covered entity is permitted to disclose the PHI directly to a business associate of the other covered entity. In addition, a health insurer or HMO may disclose PHI to a health plan, or a business associate of the health plan (for example, a third party administrator), because the relationship between the insurer or HMO and the health plan constitutes an organized health care arrangement as defined by the privacy rule.