Liberty Healthcare Corporation
THE FREEDOM TO SUCCEED™

Standard Operating Policies - SOP # 6: HIPAA Authorization Requirements

Title:	**HIPAA - Authorization Requirements**	Effective Date:	**10/03/2014**
Author:	**Privacy Officer**	Last Review Date:	**12/01/2021**
Location:	**All Locations**	Last Revision Date:	**12/01/2021**
Functional Area:	**ADMINISTRATION**		

POLICY

A valid authorization shall be obtained, by either Liberty as the Covered Entity/ Business Associate or its Covered Entity client, prior to any use or disclosure of PHI for a purpose other than those described in Standard Operating Procedure ("SOP"), "HIPAA USES AND DISCLOSURES AND MINIMUM NECESSARY", including marketing or sale of PHI.

PROCEDURE

1. If Liberty uses or discloses PHI for any purpose other than those described in SOP – "HIPAA Uses and Disclosures and Minimum Necessary", Liberty shall obtain a HIPAA-compliant authorization – "Authorization to Use or Disclose Protected Health Information" which can be found attached to this SOP.
2. As noted on the "Authorization to Use or Disclose Protected Health Information" attached to this SOP, Liberty shall not condition the provision to an individual for treatment or payment on the provision of an authorization.
3. Liberty shall obtain a valid authorization to use or disclose PHI for its own or a Covered Entity client's marketing purposes, as defined under HIPAA (45 C.F.R. 16.508(3)). If Liberty uses or discloses PHI for marketing that involves direct or indirect payment from a third party, the authorization from the individual shall state that payment is involved in order to be valid. Any use or disclosure of PHI by Liberty for marketing purposes shall also be in compliance with any applicable Business Associate Agreements.
4. Liberty shall obtain a valid authorization before engaging in any sale of PHI. An authorization for sale of PHI must state that Liberty is receiving payment for the disclosure. Liberty shall also comply with any applicable Business Associate Agreement obligations if engaging in the sale of PHI.

Refer to Information Security SOP for Access Management for new employees

See PHI Authorization under Forms on the Shared Drive

Approved By: John G. Beck Digitally signed by John G. Beck Date: 2022.01.10 14:08:49 -05'00'

Authorization to Use or Disclose Protected Health Information

Once completed the attached authorization to release records permits Liberty Healthcare Corporation and Its Affiliates (Liberty) OR its designee to disclose records in accordance with the authorization as provided herein.

Name: _____

Address: _____

Date of Birth: _____

All sections must be completed.

Section A. Health Information to be Used and/or Disclosed

Health information to be released and /or used, including (if applicable) the time period(s) to which the information relates. Select ONLY ONE of the following:

☐ All of my past, present or future health claims and/or medical records maintained by Liberty.

☐ All of my health information relating to Claim # _____ OR Date of Service _____

☐ Other (MUST specify) _____

Section B. Person(s) Authorized to Use and/or Receive Information

Specify the person(s) or class of people authorized to use and/or receive information described in Section A

_____

Section C. Purposes for which information will be Used and/or Disclosed

☐ To facilitate the resolution of a claims dispute

☐ Other (MUST specify) _____

Section D. Expiration of Authorization

Specify when this Authorization expires (Provide a date or Other – Triggering Event)

☐ On the following date: _____

☐ OTHER – Triggering Event: _____

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond the control of Liberty.

I understand that I have the right to:

1. **Revoke this authorization at any time by sending written notice to: Liberty. I am aware that such a revocation will not affect Liberty's prior reliance on the uses or disclosures pursuant to this organization.**
2. **Inspect a copy of protected health information being used or disclosed under federal law.**
3. **Receive another copy of this authorization.**

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information.

_____ _____

Signature of Individual or Individual's Authorized Representative **Date:**

NOTE—If being signed by a California individual, the authorization must be in 14 point font type.

Revision History

Version	Date	Author	Summary of Changes
#1	10/03/2014	Judith Ann Shields	Initial ISF release – refactor and update of previous security policies into distinct documents
#2	12/22/2015	Judith Ann Shields	Annual review, Attorney reviewed no changes. Added inactivity lock requirement
#3	01/18/2016	Judith Ann Shields	Annual review, Attorney reviewed no changes. Added inactivity lock requirement
#4	12/22/2017	Judith Ann Shields	Annual review, Attorney reviewed no changes. Added inactivity lock requirement
#5	12/22/2018	Judith Ann Shields	Annual review, Attorney reviewed no changes. Added inactivity lock requirement
#6	12/22/2019	Judith Ann Shields	Annual review, Attorney reviewed © LHC. Added inactivity lock requirement
#7	11/02/2020	Judith Ann Shields	Annual review, Attorney reviewed Refer to Security SOP. Added inactivity lock requirement
#8	12/01/2021	John Beck	Annual review and made minor changes. Added inactivity lock requirement