

Revisions as of 2007.10.24:

Introduction

A uniform form and process for obtaining permission from patients to use and exchange health information will facilitate the transition to electronic health records and electronic information exchange. This model permission form can assist with a smooth and rapid implementation of electronic health records because it addresses the current legal permissions necessary to exchange information regardless of purpose. This form does not resolve the larger debate around patient privacy rights versus the free flow of health information.

Phase II of the HISPC project charged Ohio's Legal Work Group (LWG) with creating a permission form that includes all legal requirements, state and federal, necessary to use and disclose patient information. The LWG began by reviewing public and private, Ohio and non-Ohio stakeholder consent/authorization forms. The LWG recognizes that many in the health care industry no longer obtain a patient's permission to use and disclose health information for treatment, payment and healthcare operations (TPO) on the basis that HIPAA does not require such permission. The LWG does not agree that HIPAA's consent provision preempts pre-existing Ohio case law requiring patient permission for TPO. Absent a legal determination that Ohio law is preempted, the LWG advocates that patient permission to use and disclose information routinely be obtained. This approach is also consistent with a patient-centric approach to medical record use and disclosure and exchange.

Upon adoption of this form, everyone will use or accept the same the form. There will be different touches with the patient where the patient is filling out the form. For example: in a physician's office for treatment or payment purposes, an attorney's office for evaluation of potential legal action, or workers' compensation for a workers' compensation claim. In other words, a patient will be completing the form at many different touch points for different purposes. Ultimately, in an electronic world, the patient record will be coded in such a way that different information can be accessed or moved around according to a patient's permissions given at various touch points within the health care system.

Recommendation

The LWG recommends that state legislation be adopted to mandate universal use or acceptance of this form in Ohio. Another alternative that has been mentioned by stakeholders is universal use of HIPAA compliant Notice of Privacy Practices amended to include Ohio law requirements for permission to use and release information for treatment, payment and health care operations. This alternative does not remove the practical concerns that have been voiced about managing patient permissions in health information exchange.

Additional issues for further discussion:

Use of SSN: The Legal Work Group truncated the Social Security number request and inserted a line for "other identifier." We recommend that the provider community consider whether a SSN is necessary on a form used to obtain permission to use and disclose information. In other words, is the SSN necessary to identify the right patient when using/disclosing information? Is there a better alternative like the medical record number or insurance plan number – especially when matched against name and birth date? Also, is it practical to include a space for an entity-defined identifier?

User friendliness: Experts at the Ohio Departments of Health and Mental Health and the Bureau of Workers' Compensation have reviewed the form for consumer readability and user friendliness. LWG cautions that legal requirements often limit the ability to make the form more user friendly.

Part B Component parts of records - what should be included in the list?

The list of types or components of medical records in Part B is now a composite of the suggestions made by the workgroup and stakeholders. The LWG suggests further review of the list.

Ohio Permission to Use/Release Health Information

This form combines all permissions needed to use and share your healthcare information in Ohio for medical care and related purposes. Private and public entities may disclose your information when required by law. Read more about these required disclosures in the *Notice of Privacy Practices*. By signing this form, you are not giving your informed consent for medical treatment.

Notice of medical record copying charges

Entities that charge individuals for copies of protected health information should insert fees and payment policy here.

The laws listed below may also apply to the release of your information.

Mental health

Stricter confidentiality rules protect your information if laws related to mental health cover any part of your records. See Ohio Revised Code (ORC) Section 5122.31. These laws prohibit anyone who receives your information from making any further disclosures without your specific written permission. A general permission for release of such information is not sufficient for this purpose. Mental health information released with your permission does not include psychotherapy notes. Also, state law may allow your provider to refuse to disclose mental health records to you if the provider thinks that releasing the information is not in your best interest.

HIV/AIDS information

Stricter confidentiality rules protect your information if laws related to HIV/AIDS cover any part of your records. See Ohio Revised Code (ORC) Section 3701.243. A general permission for release of such information is not sufficient for this purpose.

Drug and alcohol treatment records

Stricter confidentiality rules protect your information if drug and alcohol treatment laws (42 CFR Part 2) cover any part of your records. Federal law prohibits anyone who receives your information from making any further disclosures without your specific written permission. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law prohibits use of this information to criminally investigate or prosecute anyone having alcohol or drug abuse treatment records.

Medicaid and public assistance programs

If Ohio Medicaid or public assistance programs cover any part of your records, the Ohio Department of Job and Family Services (ODJFS) or a county equivalent may only release your records if you complete this form and meet all applicable conditions listed therein. These entities may only release your Ohio Medicaid (Chapter 5111 of the ORC) or public assistance information (found in Chapters 5101 and 5115) if **both** of the following apply:

- A. The release of information is for purposes directly connected to administering the Medicaid and/or public assistance programs as defined in either federal or state law, whichever is directly applicable;
- B. The information is released to persons or government entities that are subject to the standards of confidentiality and safeguarding of information substantially comparable to those established for the public assistance and/or Medicaid programs.

If this information is to be released for an insurance claim or tort action (lawsuit), Ohio law grants ODJFS rights of recovery against the liability of a third party for the cost of medical services paid by or billed to the agency. (See ORC Section 5101.58 and Ohio Administrative Code (OAC) Rule 5101:3-1-08.)

When you or someone on your behalf requests a financial statement (a claim) from a Medicaid provider for services paid by or to be billed to ODJFS, the provider must immediately notify the agency when it receives your request (OAC 5010:3-1-08(L)). In addition, the provider must forward a copy of the request to the ODJFS Bureau of Plan Operations' Benefit and Recovery Section. The provider must also stamp or type the following on each page of the financial statement: "Subject to right of recovery pursuant to Section 5101.58 of the Ohio Revised Code. Failure to comply may result in personal liability."

Workers' Compensation

If release of this information is for use in administering an Ohio workers' compensation claim, it is limited to medical, psychological and/or psychiatric data (excluding psychotherapy notes) causally or historically related to physical or mental injuries pertaining to that claim.

Permission to Use and Disclose Health Information

INSERT NAME & ADDRESS OF PROVIDER or
INSURER/HEALTH PLAN

Name: _____ Date of birth (mm/dd/yyyy): _____

Address: _____

Telephone numbers: (home) _____ (work) _____ (cell) _____

Workers' compensation claim number, if applicable: _____

Other identifier: _____

Social Security number (last four digits) _____

Fill out part A and sign Part C to grant permission for medical care, payment of medical care or other purposes related to medical care.

If you want to release information for other purposes, including a workers' compensation claim, fill out Part B and sign Part C.

PART A - General Medical Use or Release

I give permission to (insert provider name or insurer/health plan) _____ to use or release relevant personal health information to any healthcare provider, facility, insurer or health plan so that I may receive treatment, pay for treatment or allow (insert provider or insurer/health plan) _____ to conduct business necessary to treat or provide me with health care services. The person or entity will use or disclose only the minimum amount of information necessary.

This permission includes records relating to (check if applicable):

Yes No

- Diagnoses and/or treatment for alcohol and/or drug abuse or dependency;
 AIDS/AIDS-related complex (ARC) or HIV status diagnoses and/or treatment;
 Mental health records.

I request the following restrictions on the general release of my health information. I understand that my healthcare provider must agree with these restrictions:

**PART B – Multipurpose Use or Release
(when the request is not for general medical release)**

I authorize (insert provider name or insurer/health plan) _____ to disclose:

All records (whether originally created or obtained from others) Yes ___ No ___

OR (choose from below)

- | | | | | |
|-----|-----|---|-----|-----|
| Yes | No | | Yes | No |
| ___ | ___ | Hospital inpatient visit* | ___ | ___ |
| ___ | ___ | Emergency department visit* | ___ | ___ |
| ___ | ___ | Skilled nursing facility / long term care records | ___ | ___ |
| ___ | ___ | Physician office visit and related testing* | ___ | ___ |
| ___ | ___ | Dental records | ___ | ___ |
| ___ | ___ | Assessments** | ___ | ___ |
| ___ | ___ | Physicians orders | ___ | ___ |
| ___ | ___ | Transfer/discharge summary | ___ | ___ |
| ___ | ___ | Care and treatment plan and revisions | ___ | ___ |
| ___ | ___ | Admission notes | ___ | ___ |
| ___ | ___ | Nursing notes | ___ | ___ |
| ___ | ___ | Consult reports | ___ | ___ |
| ___ | ___ | History and physical | ___ | ___ |
| ___ | ___ | Narrative summary operative reports | ___ | ___ |
| | | | ___ | ___ |

* Documentation may include labs, radiology reports and images, and transcribed reports.

** To include history and physical examination, immunizations, psychiatric, nursing, social work, adjunctive therapy evaluations, and physical, occupational and athletic trainer assessments and notes, as applicable

This permission includes records relating to (check if applicable):

- | | | |
|-----|-----|---|
| Yes | No | |
| ___ | ___ | Diagnoses and/or treatment for alcohol and/or drug abuse or dependency; |
| ___ | ___ | AIDS/AIDS-related complex (ARC) or HIV status diagnoses and/or treatment; |
| ___ | ___ | Mental health records. |

Send this information by (circle one) U.S. mail or electronically to:

Name

Email

Address

City, State, ZIP code

Telephone

Fax

I understand that sending information electronically may not be a secure means of transmitting these records and that someone other than the person named above might see the information, whether by accident or on purpose. I also understand that some entities may be unable to transmit information electronically.

If this is a workers' compensation claim, information will be released to the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio (IC) and the following individuals or entities previously identified who are parties to my claim: the employer of record and/or any authorized representative(s), the employer of record's managed care organization (MCO) or qualified health plan (QHP), and my authorized representative(s).

Purpose of disclosure:

- | | | |
|-----|-----|--|
| Yes | No | |
| ___ | ___ | At my request |
| ___ | ___ | Workers' compensation; for use in administering my Ohio workers' compensation claim identified above |
| ___ | ___ | Other – Describe why you are disclosing information: _____ |

PART C - Signature

By signing below, I understand that:

I have the right to revoke this authorization at any time by giving written notice to (insert name and address). This revocation must be in writing except in the case of drug and alcohol treatment records

(insert name)_____ will honor my revocation after (insert name)_____ receives it, but I understand that my revocation will have no impact on uses or disclosures made while my authorization was in effect.

This authorization will remain in effect until (*insert specific date or completion of event*) _____ or until I revoked it, whichever comes first. If this authorization is for my workers' compensation claim, this authorization will remain in effect for as long as my workers' compensation claim remains open under Ohio law.

Except as noted in the instructions, any information used or disclosed by this specific authorization may be re-disclosed by the person or entity receiving the information and may no longer be protected by federal or state law.

I have a right to inspect or copy my protected health information. You may charge me a reasonable fee for copies of my information. See instructions for the charges that apply.

If by law you cannot send the protected health information to the entity listed above, I will initial the following space to have you send a copy of the information directly to me:_____.

I am not required to sign this authorization. If I refuse to sign this form, it will not affect my treatment, payment for treatment or eligibility for healthcare benefits to which I may be entitled. However, if I request a release of information, you cannot release it unless I sign this form. Refusing to sign may affect my eligibility for workers' compensation benefits if I have a claim.

I have a right to receive a copy of this signed form.

Signature

Patient:_____ Date:_____

Personal/legal representative: I, (*please print your name*) _____, represent that I am the (*circle one*): legal healthcare agent/guardian/surrogate/parent of the patient named above.

Personal/legal representative:_____ Date:_____

Signature: _____