



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION REQUIRING AUTHORIZATION	POLICY NO. 500.1	EFFECTIVE DATE 12/15/03	PAGE 1 of 8
APPROVED BY:  <div style="text-align: right;">Director</div>	SUPERSEDES 500.1	ORIGINAL ISSUE DATE 04/14/03	DISTRIBUTION LEVEL(S) 1

PURPOSE

- 1.1 To establish a policy and procedure applicable to all Department of Mental Health (DMH) facilities, programs and workforce members regarding the use and disclosure of Protected Health Information (PHI) and necessary authorization under the HIPAA Privacy Rule for such use and disclosure, when the use or disclosure is for purposes outside of those permitted relating to treatment, payment of mental health care operations, or under other provisions of the HIPAA Privacy Rule.

POLICY

- 2.1 It is the policy of DMH to obtain an individual's written authorization before using or disclosing PHI for purposes other than treatment, payment or mental health care operations, except as permitted by the HIPAA Privacy Rule. Use and disclosure of an individual's PHI will be consistent with the valid authorization obtained from that patient.

DEFINITIONS

- 3.1 **"Disclosure"** means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.
- 3.2 **"Marketing"** means to make a communication about a product of service a purpose of which is to encourage recipients of the communication to purchase or use the product or service. Marketing excludes a communication made to an individual:
- 3.2.1 To describe the entities participating in a mental health care provider network or health plan network, or to describe if, and the extent to which, a product or services (or payment for such product or service) is provided by a covered entity or included in a plan for benefits;
 - 3.2.2 For treatment of that individual; or
 - 3.2.3 For case management or care coordination for that individual, or to direct or recommend alternative treatments, therapies, health care providers, or setting of care to that individual.



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- 3.3 **“Protected Health Information”** (PHI) means individually identifiable information relating to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
- 3.4 **“Use”** means, with respect to PHI, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PROCEDURES

- 4.1 The language of the authorization shall be in the form as provided in the **DMH Authorization for Use or Disclosure of Protected Health Information Form** (Attachment I).
- 4.2 **Required Elements**. To be valid, an authorization must contain the elements listed below:
- 4.2.1 **Description of PHI** A specific, meaningful description of the PHI to be used or disclosed;
 - 4.2.2 **Identity of Disclosing Party** The name or other specific identification of the person(s) or class of persons authorized to disclose the PHI;
 - 4.2.3 **Identity of Recipient** The name or other specific identification of the person(s) or class of persons authorized to use or otherwise receive the PHI, if any;
 - 4.2.4 **Purpose of Use or Disclosure** A description of each purpose of the requested use of disclosure, including limitation on the recipient’s use of the PHI, if any;
 - 4.2.4.1 The statement “at my request” by the patient is a sufficient description for an authorization initiated by the patient.
 - 4.2.5 **Expiration Date** The end date for the permission granted by the authorization, which must be a specific date or event after which DMH is no longer authorized to disclose the PHI.
 - 4.2.5.1 An authorization for use and disclosure of PHI for research purposes, including for the creation or maintenance of a research database, the patient should select a date far enough in the future to cover the probable end of the research. For the research database, the patient should select



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a date such as January 1, 2003, that is far enough in the future to make clear his/her intent to make the authorization indefinite

- 4.2.6 Statement of Right to Revoke The authorization must include a statement that the individual has a right to revoke the authorization. The statement must also explain how revocation is accomplished, including that it must be in writing, and tell the individual about exceptions applicable to the revocation. These exceptions are listed below in "Implementation of Revocation".
- 4.2.7 Signature Signature of the individual and date of signature. An authorization signed by a personal representative of the individual must include a description of the personal representative's authority to act for the individual.
- 4.2.8 Authorization as a Condition The authorization must state that DMH cannot condition treatment, payment, enrollment in the health plan, or eligibility for benefits on obtaining a signed authorization, except:
 - 4.2.8.1 DMH may condition the provision of research-related treatment on obtaining an authorization for use and disclosure of PHI for research.
- 4.2.9 Redisclosure The authorization must state that the PHI disclosed to others may not be further used or disclosed by the recipient unless a new authorization is signed by the individual, or such use or disclosure is specifically required or permitted by law.
- 4.2.10 Copy The authorization must state that an individual signing the authorization has the right to receive a copy of it.
- 4.2.11 Font Size The authorization form must be printed in a least 14 point font.
- 4.3 DMH shall provide the Authorization Form upon a patient's request or in conjunction with any authorization initiated by DMH for the disclosure of PHI.
- 4.4 If the patient initiates the authorization, DMH shall establish the identity of the requestor in accordance with the Verification of Identity and Authority Policy and Procedure.
- 4.5 DMH shall explain the authorization language to the patient or personal representative, and obtain signature on the Authorization Form.
- 4.6 DMH shall ensure that all required elements listed in Section 4.2 above are completed.



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- 4.7 DMH shall provide the patient or personal representative a copy of the signed Authorization Form.
- 4.8 Compound Authorizations A HIPAA authorization applies only to the use and disclosure of PHI and may be combined with another type of written permission only as follows:
- 4.8.1 An authorization for use and disclosure of PHI for a research study may be combined with any other written permission for the same research study, such as the patient consent to participate in the research study, so long as the HIPAA authorization portion is clearly separate from any other language present on the same page and is executed by a signature for the sole purpose of executing the authorization.
- 4.9 Defective Authorizations An authorization is not valid, or is no longer valid, and may not be relied upon to use or disclose PHI, if:
- 4.9.1 The expiration date has passed;
- 4.9.2 Any required element for a valid authorization is missing;
- 4.9.3 DMH has received written revocation of the authorization;
- 4.9.4 DMH knows that important information in the authorization is false;
- 4.9.5 The authorization violates restrictions on compound authorizations as set forth in Section 4.8.
- 4.10 Conditions DMH may not condition the individual's treatment upon obtaining an authorization except:
- 4.10.1 DMH may condition research-related treatment on provision of a HIPAA authorization for use or disclosure of PHI.
- 4.10.2 DMH may not condition the provision of mental health care on obtaining an authorization even if the only purpose of providing the mental health care is to create PHI for disclosure to a third party (e.g., fitness for duty, school or summer camp physical, pre-employment examinations.)
- 4.10.2.1 DMH will disclose the PHI directly to the patient, unless DMH receives a signed HIPAA authorization from the patient for the disclosure to the third party.



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4.11 Authorization for Marketing

4.11.1 DMH must obtain an Authorization for any use or disclosure of PHI for marketing, except if the marketing communication is in the form of:

- 4.11.1.1 Face-to-face communications to the patient by DMH; or
- 4.11.1.2 A gift to the patient from DMH of nominal value, e.g., a pen with a DMH logo.

4.11.2 If the marketing involves direct or indirect remuneration to DMH from a third party, the Authorization must state that such remuneration is involved.

4.12 Implementation of Revocation

4.12.1 A patient may revoke or modify his or her authorization in writing.

4.12.2 A modification or revocation is valid, except to the extent DMH has taken action in reliance on such Authorization.

4.12.3 The individual may use the Revocation or Authorization at the bottom of the Authorization Form or write their own revocation.

4.13 Use and Disclosure of HIV Test Results Except as specifically set forth below, HIV test results, whether positive or negative, or even the fact that an HIV test was ordered, may be disclosed only pursuant to a valid, written authorization.

4.13.1 Use and Disclosure of HIV Test Results Pursuant to a Written Authorization To be valid, an authorization for use or disclosure of a HIV test result must be signed by the same individual who validly signed the consent for the HIV test and who is one of the following;

- 4.13.1.1 An adult with medical decision-making capacity;
- 4.13.1.2 A minor who is twelve (12) years of age or older and mature enough to give effective informed consent to an HIV test;
- 4.13.1.3 A parent or legal guardian for a minor under twelve (12) years of age; or
- 4.13.1.4 A conservator or agent pursuant to a power of attorney for health care.



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4.13.2 Requirements for a Written Authorization for Use or Disclosure of HIV Test Results

- 4.13.2.1 To be valid, an authorization for use or disclosure of HIV test results must contain all of the elements set forth in Section 4.2 above.
- 4.13.2.2 Additionally, the authorization must specifically state that it authorizes the use or disclosure of HIV test results and must be signed by a witness.
- 4.13.2.3 A general authorization for the use or disclosure of medical records is *not* sufficient to authorize use or disclosure of HIV test results.
- 4.13.2.4 If only a general authorization for use or disclosure of medical information is received, that does not specifically authorize the use or disclosure of HIV test results, the HIV test results must be redacted from the information that is used or disclosed. if any, and may *not* be used or disclosed.
- 4.13.2.5 A separate written authorization must be obtained for each Use or Disclosure of an HIV test result.

4.13.3 Exceptions to the Written Authorization Requirement HIV test results may, but are not required to, be disclosed to the following persons without the written authorization of the test subject.

- 4.13.3.1 The subject of the test or the subject’s legal representative, conservator, or to any person authorized to consent to the test.
- 4.13.3.2 The subject’s provider of health care for the purpose of diagnosis, care, or treatment of the patient (but not to a health care service plan);
- 4.13.3.3 An agent or employee of the test subject’s provider of health care who provides direct patient care and treatment;
- 4.13.3.4 A provider of health care who procures, processes, distributes, or uses a human body part donated pursuant to the Uniform Anatomical Gift Act, as well as to a procurement organization, a coroner, or a medical examiner in conjunction with such donations;
- 4.13.3.5 The “designated officer” of an emergency response employee, or from that designated officer to an emergency response employee, regarding possible exposure to HIV or AIDS, but only to the extent necessary to



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comply with the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (42 U.S.C. § 201).

- 4.13.3.6 In some instances, to a health care worker who has been exposed to the potentially infectious materials of a patient, provided that strict procedures for consent and testing are followed. Legal counsel should be consulted with regard to such disclosures;
- 4.13.3.7 A court pursuant to a court order for disclosure of HIV test results of a defendant to a criminal charge; and
- 4.13.3.8 A county health officer (without identifying the individual believed to be infected).
- 4.13.4 Disclosure to Persons at Risk of Infection In addition to the foregoing, a patient's physician may, but is not required to, disclose a positive HIV test result to specified individuals under circumstance indicating that such individual may be in danger of HIV infection.
 - 4.13.4.1 The physician may make a disclosure to the following:
 - 4.13.4.1.1 Any person known or believed to be the spouse of the test subject.
 - 4.13.4.1.2 Any person known or believed to be a sexual partner of the test subject; and
 - 4.13.4.1.3 Any person known or believed to have shared hypodermic needles with the test subject.
 - 4.13.4.2 Before disclosing test results under this provision, the physician must do the following:
 - 4.13.4.2.1 Provide appropriate education and psychological counseling for the test subject;
 - 4.13.4.2.2 Inform the test subject of the physician's intent to notify such person; and
 - 4.13.4.2.3 Attempt to obtain voluntary consent from the test subject. If consent cannot be obtained, the results may then be disclosed but



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only for the purpose of obtaining care, follow-up, and/or treatment for the person(s) to whom disclosure is made and to interrupt the chain of infection.

- 4.13.4.3 The disclosing physician must refer the person notified for appropriate care, counseling, and follow-up. The physician *may not* disclose any identifying information about the test subject.

DOCUMENT RETENTION

- 5.1 DMH shall document and retain all documents required to be created or completed by this policy.
 - 5.1.1 Signed Authorizations must be retained for at least six (6) years after the date they were last in effect.
 - 5.1.2 Revoked Authorization and revocation documents must be retained for at least six (6) years after the date DMH receives revocation documents.

AUTHORITY

Code of Federal Regulations Part 160 and 164; Section 164.508 "Use and Disclosure for which an Authorization is Required
 Cal. Civil Code §§ 56,11(b), (g), (h), and (i), § 56.12, § 56.17 (g)(8)m § 56.245, § 56.31, 56.37(a)
 Cal. Health & Safety Code § 120980(g)
 Cal. Welfare & Institutions Code §§ 5328(b) and (d)

ATTACHMENTS

- Attachment I Authorization for Request or Use/Disclosure of Protected Health Information

**AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)**

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (“LACDMH”)

CLIENT:

Name of Client/Previous Names

Birth Date

MIS Number

Street Address

City, State, Zip

AUTHORIZES:

**DISCLOSURE OF PROTECTED HEALTH
INFORMATION TO:**

Name of Agency

Name of Health Care Provider/Plan/Other

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

INFORMATION TO BE RELEASED:

Assessment/Evaluation

Results of Psychological Tests

Diagnosis

Laboratory Results

Medication History/

Treatment

Entire Record (Justify)

Current Medications

Other (Specify): _____

PURPOSE OF DISCLOSURE: (Check applicable categories)

Client’s Request

Other (Specify): _____

Will the agency receive any benefits for the disclosure of this information? Yes No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/____/____
Month Day Year

**AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)**

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (“LACDMH”)

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

Contact person

Agency Name

Street Address

City, State, Zip

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client / Personal Representative

Date

If signed by other than the client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: ____/____/____
Month Day Year