What is an “Authorization Form”?
Authorization Forms

• Requirement of Federal and State confidentiality laws that protect health information

• Authorizes a healthcare provider to disclose person’s confidential health care information to a third party
Confidentiality Laws

Federal Laws:

• HIPAA Privacy Rule
• Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2)

State Law:

• OhioMHAS Statute/Rules
General Rule
(HIPAA, Part 2 and State Law)

- Persons/organizations covered by these laws (e.g. health care providers, health plans) must keep health information confidential
- Each law contains exceptions that permit disclosure for certain purposes
- If no exception applies to a particular disclosure, the person’s written authorization required
HIPAA-Permitted Disclosures

- Treatment, Payment and Health Care Operations
- For Public Health Purposes
- Reports of Child Abuse or Neglect
- Disclosures about Other Victims of Abuse, Neglect, or Domestic Violence
- For Judicial and Administrative Proceedings
- For Health Oversight Activities
- For Law Enforcement Purposes
- Correctional Institutions and other Law Enforcement Custodial Situations

*Note: There are specific requirements related to each of these disclosures. See the regulations for additional information prior to disclosure.*
HIPAA-Permitted Disclosures -continued-

• As Required by State or Federal Law
• To Reduce or Prevent a Serious Threat to Public Health and Safety
• Public Benefits Administration and Coordination
• National Security and Intelligence Activities
• To Coroners, Medical Examiners, and Funeral Directors
• Organ, Eye or Tissue Donation
• Protective services for the President and Others
• Disclosures for workers’ compensation

* Note: There are specific requirements related to each of these disclosures. See the regulations for additional information prior to disclosure.
42 CFR Part 2-Permitted Disclosures

- Medical emergencies
- Audit and evaluation Activities
- Research
- Child abuse and neglect Reporting
- Certain cause of death-related information
- Pursuant to Part 2 –compliant court order
- Crimes on program premises or against program personnel

*Note: There are specific requirements related to each of these disclosures. See the regulations for additional information prior to disclosure.*
When Multiple Laws Apply to a Disclosures

• Must comply with law that is most protective of the person’s information

Example:
• Provider is covered by both HIPAA and Part 2
• Disclosure is for treatment purposes
• HIPAA permits disclosures for treatment purposes without the person’s authorization
• Part 2 does not permit the disclosure without authorization
  = Authorization is required to make the disclosure!
Authorization Form Requirements
Authorization Form Requirements

- Form called something different under each law
  - Release of Information (OhioMHAS Rules), Authorization (HIPAA), Consent to Disclose (Part 2)

- Each law requires specific statements and information to be on the form
  - Form is not valid if required info missing
Common Elements:

All of the laws require the following:

• Disclosing person/organization
• Recipient
• Information to be disclosed
• Purpose of disclosure
• Expiration of authorization
• How to revoke authorization
• Signed and dated
Authorization Form Requirements

• Each law has slightly different requirements for the content of the form
  • Example: OhioMHAS certification rules require date of birth – the federal laws do not

• If more than one law protects the info, the form must contain the elements required by each applicable law
  • Example: Form must include elements required by both HIPAA and Part 2 for disclosures by SUD treatment providers
Why a “Standard” Authorization Form?
The Problem

• Each entity must draft their own form and ensure compliance with the applicable confidentiality laws
• Too many forms – nothing standardized
• Forms being rejected by providers for “non-compliance”
• Providers requiring use of own forms
• Confidentiality laws do not require disclosure of information when authorization form received
Purpose of Standardized Form

- Streamline and expedite process for obtaining needed information
- Ensure all required elements included
- Coordination of care (MH and SUD providers)
- Allow non-providers to access needed information (i.e. CJ system)
- Require disclosure as authorized by person
- Clarify when authorization required
Legal Requirements
(A) The medicaid director shall prescribe by rules ..... a standard authorization form for the use and disclosure of protected health information by covered entities in this state.

The form shall meet all requirements specified in 45 C.F.R. 164.508 and, where applicable, 42 C.F.R. part 2.
(B) If a form .... is properly executed by an individual or the individual's personal representative, it shall be accepted by any person or governmental entity in this state as valid authorization for the use or disclosure of the individual's protected health information to the persons or governmental entities specified in the form.
(C) This section *does not preclude* a person or governmental entity from *accepting* as valid authorization for the use or disclosure of protected health information *a form other than the form prescribed under division (A) of this section if the other form meets all requirements* specified in 45 C.F.R. 164.508 and, if applicable, 42 C.F.R. part 2.
O.A.C. 5160-1-32.1
Standard authorization form

- Rule in effect on January 3, 2019
- Forms must be accepted state-wide as of thirty days post effective date
- Forms in appendix A to rule
- Instructions in appendix B to rule
Standard authorization form

- Must be properly executed and adequately identify the individual

- Rule does not require obtaining authorization or use of the form when use or disclosure required or permitted without such authorization
Using the Forms
Form A

• Form A is used for disclosures of PHI by HIPAA-covered entities when HIPAA requires authorization

• HIPAA does not require authorization to disclose PHI for purposes of treatment, payment, health care operations and certain other permitted or required disclosures
Form B

• Form B is used for disclosures of Part 2-protected information by substance use disorder treatment providers/programs when Part 2 requires authorization.

• Part 2 requires authorization for most disclosures:
  • no treatment, payment, health care operations, required by law exceptions
### STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.

**FORM A – AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)**

<table>
<thead>
<tr>
<th>Section I</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Name</strong></td>
</tr>
<tr>
<td>Address</td>
</tr>
</tbody>
</table>

I hereby authorize the disclosure of health information about the above individual as follows.

<table>
<thead>
<tr>
<th>Section II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disclosing Entity</strong> (Covered Entity such as a health plan/insurer or provider)</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

**Recipient (Person or Entity)**

**Contact Information** *(e.g. telephone number, email address, fax number, street address, etc.)*

<table>
<thead>
<tr>
<th>Section III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason for Disclosure</strong></td>
</tr>
</tbody>
</table>

**Health information to be disclosed**

Specify time period, if desired:
Release only information from the period *(mm/dd/yyyy)* to *(mm/dd/yyyy)*

<table>
<thead>
<tr>
<th>Section IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This authorization will remain in effect until revoked or shall expire on date or event specified below.</strong> I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.</td>
</tr>
<tr>
<td><strong>Expiration Date or Event</strong> <em>(mm/dd/yyyy)</em></td>
</tr>
</tbody>
</table>

* I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.

* I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

**Signature of Individual**

**Signature of Personal Representative (if applicable)** *(Identify relationship to individual below)*

**Relationship of Personal Representative to Individual** *(Personal representative shall submit proof of authority to the disclosing entity)*

☐ Parent  ☐ Legal Guardian  ☐ Healthcare Power of Attorney  ☐ Executor/Administrator  ☐ Other  ☐ N/A

For administrative use only:

**Method of Delivery** *(e.g. paper, fax, electronic,)*

**Date Released**

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**ODM 10221 (1/2019)**
FORM B — CONSENT FOR RELEASE OF PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION

A Part 2 Program is a federally assisted (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment, or referral for treatment; (ii) an identified unit within a general medical facility that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment; or, (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment, and who are identified as such providers.

<table>
<thead>
<tr>
<th>Section I</th>
<th>First Name*</th>
<th>M.I.</th>
<th>Last Name*</th>
<th>Date of Birth*</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby authorize the disclosure of health information about the above individual as follows.

<table>
<thead>
<tr>
<th>Section II</th>
<th>Disclosing Entity*</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

The information is to be provided to the following*:
- [ ] Named Individual:
- [ ] Named Third Party Payor:
- [ ] Named Treatment Provider Entity:
- [ ] Named Non-Treatment Provider (such as an intermediary or research entity)*
  - [ ] If non-treatment provider is selected complete a, b and/or c below:
    - a. Named Individual Participant(s): ____________________________
    - b. Named Treatment Provider Entity Participant(s): ____________________________
    - c. Description of Group or Class of Treatment Provider Entity Participant(s): ____________________________

| Contact Information | (e.g. telephone number, email address, fax number, street address, etc.) |

<table>
<thead>
<tr>
<th>Section III</th>
<th>Reason for Disclosure*</th>
<th>Health information to be disclosed*</th>
</tr>
</thead>
</table>

Specify time period, if desired:
- Release only information from the period ______________ (mm/dd/yyyy) to ______________ (mm/dd/yyyy)

<table>
<thead>
<tr>
<th>Section IV</th>
<th>Expiration Date or Event</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient.</td>
</tr>
<tr>
<td></td>
<td>I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services.</td>
</tr>
<tr>
<td></td>
<td>If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Individual*</th>
<th>Date* (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Personal Representative (if applicable)*</td>
<td>(Identify relationship to individual below)</td>
</tr>
<tr>
<td>Relationship of Personal Representative to Individual</td>
<td>(Personal representative shall submit proof of authority to the disclosing entity)</td>
</tr>
<tr>
<td>[ ] Parent</td>
<td>[ ] Legal Guardian</td>
</tr>
</tbody>
</table>

For administrative use only:
- Method of Delivery (e.g. paper, fax, electronic) | Date Released |

ODM 10221 (1/2019)
Form Instructions

• Must be “properly executed”
  • All fields marked with an * must be completed
  • Other fields should be completed if known to help identify the person’s records
  • Person must be adequately identified so records can be located

• “Health Information to be Disclosed” must be specific

• Form will expire in one year if a different date or event is not listed

• Must be signed and dated by the person (or personal representative of person)
Additional Considerations
• Can be used by anyone – Authorization can be obtained by courts, attorneys, law enforcement, etc.

• Information MUST BE disclosed when valid form received

• Form can be copied and additional fields or statements added such as language for 2-way exchange of information however would not be statutory form so not required to be accepted
Criminal Justice-Specific Requirements

- Form B does not address Part 2’s additional requirement for the disclosure of information to the Criminal Justice system about a person that is required to participate in a treatment program as a condition of the disposition of criminal proceedings or of parole or other release from custody.

- Part 2 requires authorization forms used for such purposes to include a statement that the form is not revocable until a certain time or event related to the final disposition of the proceeding or release.

- ODM has agreed to include language to address this requirement in the next version of the form.

- For now, providers can continue to use their current forms containing this language or they can add the following to Form B to make it compliant with the Part 2 requirement.
Criminal Justice-Specific Language

• Add the following to the revocation statement in Section IV:

  See exception note below

• In the fillable box titled *Expiration Date or Event* enter the following sentence:

  *If authorizing disclosure of information to the criminal justice system about the individual's court-mandated treatment, it may not be revoked until the final disposition of the criminal proceeding and/or the individual’s release from custody or supervision.*

** The addition of this language to Form B has been approved by ODM **
Resources
Resources

Ohio’s Standard Authorization Forms - fillable
https://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM10221fillx.pdf

Instructions for Completing Form
https://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM10221i.pdf

Form Instructional Video
https://www.youtube.com/watch?v=3wVBC6_l_Zc

Form Questions
standardauthorizationform@Medicaid.ohio.gov
Thank you!!