HIPAA

Health Insurance Portability and Accountability Act of 1996

Updated July 2016

CTSI
Serving Colorado's Counties

HIPAA Authorization to Release PHI

Authorizations to release Protected Health Information (PHI) are required only under certain circumstances. See enclosed HIPAA Authorization Memo as well as the three authorization forms provided in this section.

Updated June 2021

CTSI
Serving Colorado's Counties

June 17, 2005

MEMORANDUM

TO: County Health Pool Contacts

FROM: Meredith Burcham, Benefits Manager

RE: HIPAA and Authorization to Release PHI

Attached you will find a memo regarding authorizations as well as three different Authorization Forms. These forms are numbered to assist with differentiation.

Form 1 is the most general and long term use release. This allows disclosure from and to anyone assisting the authorizing person for the time he/she is participating in County Health Pool.
Form 2 is less general and designates only those listed on the form to provide, receive and use the described information, for the listed purpose, for the time the authorizing person is participating in County Health Pool.
Form 3 is the most specific and lists who may provide, receive and use the specifically described information, for the listed purpose, for a specified time period.

After ongoing discussion with consultants and CHP's legal counsel, it has been determined that in order to best protect CHP and our Members against any potential future liability, use of these forms should begin immediately.

Please contact me with any questions. Thank you.

CTSI
Serving Colorado's Counties

June 17, 2005

MEMORANDUM

TO: County Health Pool Contacts
FROM: Meredith Burcham, Benefits Manager
RE: HIPAA and Authorization to Release PHI

It is our understanding of the law that authorizations to release Protected Health Information (PHI) are required under certain circumstances only. Following are two scenarios and how we would handle and are instructing our Members to handle.

Scenario 1 – **Claimant** directly contacts CTSI staff (staff directly handling CHP matters) either telephonically, via email, U.S. mail or fax and requests assistance with a claim. CTSI staff can work directly with the **claimant** (**claimant** only, unless unemancipated dependent, in which case we can work with the parent) after reasonably attempting to verify that indeed we are in contact with the **claimant**. We can do this without an authorization.

In the case of a Member being directly contacted in the same manner as described above, they also do not need an authorization.

Generally, a claimant may contact the Member about health plan information or claim/eligibility questions without an authorization, since it is the individual's PHI they are discussing/ disclosing on themselves. However, the Member cannot discuss the individual's claim or other CHP health plan information with CTSI or other CHP Business Associates (VSP, Anthem BCBS, Advance PCS, etc.) without an individual authorization from the claimant. The Member and CHP have specified with whom at the Member entity CTSI can discuss employee questions – the Contact Person as designated by the Designated Representative form.

Scenario 2 - If the Member is directly contacted by a **claimant** and they call CTSI **with the claimant present**, the Member and/or CTSI do not need an authorization. However, if the Member is directly contacted by the **claimant** and requires assistance from CTSI **and the claimant is not present**, the Member must get an authorization from the **claimant** to work with CTSI. CTSI will require an authorization before we can work with the Member.

Assuming CTSI can verify that the individual calling is the **claimant** and that individual gives the Member verbal authorization to discuss the matter, no written authorization is needed. CTSI can discuss the **claimant's** information only with the contact person at the Member's office.
If the Member is directly contacted by the **claimant** and requires assistance from CTSI (or other BA) and the **claimant** is not present, a written authorization is required from the **claimant**. CTSI should obtain the original, not a copy, of the individual's authorization before discussing any PHI-related matters with the Member.
(CTSI will allow faxed copies of authorizations until the original is mailed).
June 17, 2005

CTSI
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What documents need to be submitted if there is a HIPAA qualifying event (Special Enrollment)?

1. Completed and Signed Enrollment Application/Change Form
2. Supporting Documentation
    a. Involuntary loss of coverage
        i. Letter from employer stating involuntary loss of coverage or termination of employment. A Certificate of Credible Coverage from the former group health plan is also acceptable.
        ii. Affidavit of Responsibility required if adding step-children or Permanent Guardianship.
            1. Copy of divorce decree or other court documents showing responsibility for providing benefits and last year's tax return showing who claimed the child.
    b. Marriage
        i. Copy of Marriage Certificate or Civil Union Registration.
        ii. Domestic Partner (see Appendix 5), if applicable.
        iii. Common-Law Affidavit (see Enrollment Application/Change Form, Section 8), if applicable.
        iv. Affidavit of Responsibility required if adding step-children or Permanent Guardianship.
            1. Copy of divorce decree or other court documents showing responsibility for providing benefits and last year's tax return showing who claimed the child.
    c. Birth
        i. Copy of Birth Certificate or Hospital Certificate, when it is received.
    d. Adoption or placement for adoption
        i. Copy of Court Documents showing Legal Adoption.

What changes can be made if there is a HIPAA qualifying event (Special Enrollment)?

1. Involuntary loss of coverage
    a. Add any employee and/or spouse/dependents that experienced loss of previous coverage. If the employee already has coverage with CHP and would like to add spouse or dependents, they will be added to the employee's current plan.
2. Marriage
    a. Add spouse and step-children affected by the marriage. If the employee already has coverage with CHP and would like to add spouse or dependents, they will be added to the employee's current plan.
3. Birth
    a. Add spouse and/or newborn affected by the birth. If the employee already has coverage with CHP and would like to add spouse or dependents, they will be added to the employee's current plan.
4. Adoption or placement for adoption
    a. Add spouse and/or children affected by the adoption. If the employee already has coverage with CHP and would like to add spouse or dependents, they will be added to the employee's current plan.

****** All changes must be made within 31 days after the date of the Qualifying Event (60 days for a Qualifying event defined as a loss of Medicaid, CHIP coverage or eligibility for state premium assistance).**

CTSI
Serving Colorado's Counties

Updated July 2016

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Insured/Member Name: _____ ID No. _____

I hereby authorize the use or disclosure of my health information while I am participating in County Health Pool.

I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting the CHP Privacy Officer, 800 Grant St., Suite 400, Denver, CO 80203, (303) 861-0507. A revocation is only effective after it is received and logged by County Health Pool, and any use or disclosure made prior to a revocation under this authorization will not be affected by a later revocation.
- I may inspect and/or copy the health information described above.
- The information disclosed may be subject to further disclosure by the recipient and would no longer be protected by HIPAA.
- I may refuse to sign this authorization and my treatment or payment will not be conditioned on my refusal to sign, unless the authorization is for treatment related to research.
- I will be informed if the person requesting the information is to receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- I am entitled to receive a copy of this authorization.

This authorization is effective from the date signed below until I terminate coverage through County Health Pool.

_____ _____

Signature of Insured/Member or Personal Representative Date

Printed Name of Personal Representative: _____

Relationship to Insured/Member: _____

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Insured/Member Name:_____ ID No. _____

I hereby authorize the use or disclosure of my health information while I am participating in County Health Pool.

(1) *Person/organization (or class of persons) authorized to provide the information:*

_____

(2) *Person/organization (or class of persons) authorized to receive and use the information:*

_____

(3) *Description of the information:*

_____

_____

(4) *Purpose of the disclosure:* (Please state the purpose of the disclosure below. If you do not wish to state a purpose, please state, "At the request of the individual.")

_____

(5) I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting the CHP Privacy Officer, 800 Grant St., Suite 400, Denver, CO 80203, (303) 861-0507. A revocation is only effective after it is received and logged by County Health Pool, and any use or disclosure made prior to a revocation under this authorization will not be affected by a later revocation.
- I may inspect and/or copy the health information described above.
- The information disclosed may be subject to further disclosure by the recipient and would no longer be protected by HIPAA.
- I may refuse to sign this authorization and my treatment or payment will not be conditioned on my refusal to sign, unless the authorization is for treatment related to research.
- I will be informed if the person requesting the information is to receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- I am entitled to receive a copy of this authorization.

(6) This authorization is effective from the date signed below.

_____

_____ _____

Signature of Insured/Member or Personal Representative Date

Printed Name of Personal Representative: _____

Relationship to Insured/Member: _____

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Insured/Member Name:_____ ID No. _____

I hereby authorize the use or disclosure of my health information as described in this authorization.
(1) *Specific person/organization (or class of persons) authorized to provide the information:*

_____

(2) *Specific person/organization (or class of persons) authorized to receive and use the information:*

_____

(3) *Specific and meaningful description of the information:*

_____

_____

(4) *Purpose of the disclosure:* (Please state the purpose of the disclosure below. If you do not wish to state a purpose, please state, "At the request of the individual.")

_____

(5) I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting the CHP Privacy Officer, 800 Grant St., Suite 400, Denver, CO 80203, (303) 861-0507. A revocation is only effective after it is received and logged by County Health Pool, and any use or disclosure made prior to a revocation under this authorization will not be affected by a later revocation.
- I may inspect and/or copy the health information described above.
- The information disclosed may be subject to further disclosure by the recipient and would no longer be protected by HIPAA.
- I may refuse to sign this authorization and my treatment or payment will not be conditioned on my refusal to sign, unless the authorization is for treatment related to research.
- I will be informed if the person requesting the information is to receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- I am entitled to receive a copy of this authorization.

(6) This authorization is effective from the date signed below until the following date or event:

_____

_____ _____

Signature of Insured/Member or Personal Representative Date

Printed Name of Personal Representative: _____

Relationship to Insured/Member: _____