**Statewide Health Information Policy Manual (SHIPM) 2.1.1 – Authorizations**

*Compliance Review Tool Question #1*

## Artifact Must Haves and Best Practices

| **Item #** | **Topic** | **Covered (Y or N)** | **Comment** |
| --- | --- | --- | --- |
| 1 | Was an **Authorization P&P** submitted for review? | Y🞏 N🞏 |  |
| 1a | * Does the artifact(s) indicate that health information can be used or disclosed without authorization for certain specific purposes and that all other uses and disclosures of health information require prior authorization from the patient? | Y🞏 N🞏 |  |
| 1b | * Does the artifact(s) indicate that when an authorization is received, health information may be used or disclosed for the purpose specifically listed in the authorization? | Y🞏 N🞏 |  |
| 1c | * Does the artifact(s) require the authorization be written in plain language, and printed/displayed in 14-point font? | Y🞏 N🞏 |  |
| 1d | * Does the artifact(s) include procedures for processing: | Y🞏 N🞏 |  |
| 1e | * Modifications or revocations of authorizations? | Y🞏 N🞏 |  |
| 1f | * Defective/non-valid authorizations including: | Y🞏 N🞏 |  |
| 1g | * + Compound authorizations? | Y🞏 N🞏 |  |
| 1h | * + The expiration date has passed? | Y🞏 N🞏 |  |
| 1i | * + The required elements have not been filled out completely? | Y🞏 N🞏 |  |
| 1j | * + The authorization is known by the state entity to have been revoked? | Y🞏 N🞏 |  |
| 1k | * + The authorization violates state or federal law on compound authorizations and/or the prohibition on conditioning of authorizations? | Y🞏 N🞏 |  |
| 1l | * + Any material information in the authorization is known by the state entity to be false? | Y🞏 N🞏 |  |
| 1m | * Does the artifact(s) ensure the state entity retains any authorization, modifications or revocations applied to authorizations for a minimum of six (6) years from date of request? | Y🞏 N🞏 |  |
| 2 | Does the artifact(s) have official review/acceptance: |  |  |
| 2a | * Effective Date? | Y🞏 N🞏 |  |
| 2b | * Revision Date? | Y🞏 N🞏 |  |
| 2c | * Authorizing Sr./Executive Management Signature? | Y🞏 N🞏 |  |
| 3 | Was an **Authorization template** submitted for review? | Y🞏 N🞏 |  |
| 4 | Does the artifact(s) include the following: |  |  |
| 4a | * A specific description of the health information to be disclosed. | Y🞏 N🞏 |  |
| 4b | * The types of information listed below must be specifically identified in authorizations, if part of the disclosure includes:   + HIV/AIDS test results   + Mental health records   + Genetic test results   + Substance abuse treatment records | Y🞏 N🞏 |  |
| 4c | * Name or other specific identification of the person(s), class of person(s), or organizations requesting the health information. | Y🞏 N🞏 |  |
| 4c | * The name or other specific identification of the person(s), class of person(s), or organizations to whom the health information will be disclosed. | Y🞏 N🞏 |  |
| 4e | * The purpose for the use or disclosure: |  |  |
| 4f | * + If the patient initiates the authorization, the statement “at the request of the patient” or similar language that indicates the patient’s wishes is sufficient description of the purpose. | Y🞏 N🞏 |  |
| 4g | * + When someone other than the patient initiates the authorization, the purpose for the use or disclosure of health information must be clear enough to limit use or disclosure to the extent necessary to accomplish the stated purpose. | Y🞏 N🞏 |  |
| 4h | * An expiration date or an event (e.g., end of hospitalization). When an authorization is signed by a parent, the expiration date of the authorization may be the date the minor reaches age 18. | Y🞏 N🞏 |  |
| 4i | * Patient signature and date signed. If the authorization is signed by a patient representative, a description of the representative's authority to act for the patient must also be stated. | Y🞏 N🞏 |  |
| 4j | * Statements that:   + The patient has the right to modify or revoke the authorization in writing,   + Directions on how the patient can modify or revoke   + Lists exceptions to the right to revoke | Y🞏 N🞏 |  |
| 4k | * Statement advising the patient of his/her right to receive a copy of the authorization. | Y🞏 N🞏 |  |
| 4l | * Statement that treatment, payment, enrollment, or eligibility for benefits cannot be conditioned upon patient authorization. | Y🞏 N🞏 |  |
| 4m | * The HIPAA required statement: “Health information disclosed through the authorization may be subject to re-disclosure and is no longer protected if it is disclosed to anyone other than a covered entity.” | Y🞏 N🞏 |  |

Title(s) of Submitted Policy/Document/Artifact(s) Reviewed:

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Stored Location of, or link to Artifact(s) Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Overall CalOHII Reviewer Comments:

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Name of CalOHII Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_

Title of or link to Other Source(s) used (e.g., sources not in checklist, templates) – *optional*: