AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

North Dakota Department of Health

SFN 53814 (7-05)

This form authorizes the NDDoH to use and disclose your protected health information. Please complete this form in its entirety. Contact the NDDoH Privacy Officer at 701.328.2352 if you have questions in relation to this authorization. Return this form to: Human Resources Department, Attention: Privacy Officer, ND Department of Health, 600 East Boulevard Ave., Dept. 301, Bismarck, ND, 58505-0200.

Name			
Street Address	City	State	Zip Code
Telephone Number			
Date of Birth			
Date of Request			

I _____ authorize NDDoH staff to (check all that apply):

- □ Use the following protected health information, and/or
- □ Disclose the following protected health information to:

Description of the information to be used or disclosed (Describe the specific protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.).

This protected health information is being used or disclosed for the following purposes:

This authorization is in effect until (please choose one):

- □ Date [mm/dd/yyyy] _____ (Up to 5 years)
- □ End of the research study
- □ No end date

I understand that I have the right to revoke this authorization at any time by sending a written notification to Privacy Officer, Human Resources Department, ND Department of Health, 600 East Boulevard Ave., Dept. 301, Bismarck, ND, 58505-0200.

I understand that a revocation is not effective to the extent that NDDoH staff has relied on the use or disclosure of the protected health information.

I understand that the person who receives this information may not be covered by the HIPAA privacy rule, so that person may further disclose the information as it is no longer protected by federal or state law.

We will not condition your treatment on whether you provide this authorization for the requested use or disclosure.

You are not required to sign this authorization form. If you do sign this form, you have a right to receive a copy of the completed authorization.

- □ Please provide me with a copy of this authorization form.

Signature of Individual or Personal Representative _____ Date _____

(If Personal Representative, please provide proof of identify and authority):

Copy to NDDoH Division Program File Copy to HIPAA Coordinator

GENERAL INFORMATION

An authorization is not required for use or disclosures of PHI for:

- Treatment
- Payment
- Healthcare Operations
- As Required by law
- Public health purposes
- Victims of abuse, neglect or domestic violence
- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement purposes
- Information about decedents
- Cadaveric organ, eye or tissue donation purposes
- Research purposes
- To avert a serious threat to health or safety
- Specialized government functions
- Workmen's compensation

The NDDoH will obtain an authorization to use or disclose psychotherapy notes except:

- When requested by the originator of the psychotherapy notes for treatment
- When use or disclosure is required for the NDDoH to defend itself in a legal action brought by the individual
- When required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine the NDDoH compliance with HIPAA
- When required by law
- When required for healthcare oversight
- When requested by coroners and medical examiners
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

NDDoH requires an authorization form:

- If an individual or personal representative requests PHI be disclosed to a third party
- When NDDoH requests an individual's PHI be used or disclosed for purposes other than treatment, payment, healthcare operations or as permitted by law
- When NDDoH asks an individual for permission to request their PHI from another entity solely for NDDoH's own purposes

The authorization is not valid if it does not contain the required contents, if the information is false or if the authorization has expired or has been revoked.

The authorization is retained for a period of six (6) years after it was created or expired, whichever date is later.