Illinois Department of
PUBLIC
HEALTH

Rod R. Blagojevich, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

December 15, 2007

Re: Legal Workgroup Documents

Dear Steering Committee Members:

As Chair of the Legal Workgroup, I am pleased to submit for your review documents developed by the Legal Workgroup. Each of the members played a significant role in our conference calls, contributing valuable insights and recommendations. We have had several dynamic and productive meetings as we developed model documents to support the use of a health information exchange (HIE).

Our primary approach was to provide all patients in Illinois with the same information regarding privacy protections under the law and the necessary education how their records would be safeguarded in an HIE environment. We were cognizant of the security concerns, and appreciated the need for promoting efficiencies. The Legal Work Group considered the legalities associated with the use and disclosure of health information in an HIE and developed three (3) model forms to assist health care providers, participants and organizers of HIEs: (a) a Notice of Privacy Practices insert; (2) a form of Consent and Disclosure of Certain Types/Categories of Protected Health Information; and (3) a form of Authorization for Use and Disclosure of Protected Health Information for Research. We also developed an HIE Utilization Guidelines Form that provides an overview of the forms for users to describe the form content. At our final last meeting, we agreed the forms required disclaimer language informing users to conduct a proper review prior to adopting them.

We realize that much work remains to be done, and that the framework of the HIE and electronic medical records will continue to evolve in Illinois. We hope to be able to provide further legal support and recommendations to this initiative.

Sincerely,

Marilyn Thomas
Chief Legal Counsel
Legal Workgroup Chair

Attachments

HIE FORM UTILIZATION GUIDELINES

The Health Information Security and Privacy Collaboration (HISPC) is a federal initiative to study privacy and security "challenges" for the implementation of health information exchange (HIEs) in the states. Illinois is one of 33 states and one territory participating in the collaboration.

The promise of electronic health records (EHR) and HIEs is to enhance the quality of health care provided to patients. The optimal goal is to provide all patients in Illinois with the same information regarding privacy protections under the law and the necessary education to understand how their records will be safeguarded in an EHR/HIE environment. To address this goal, the task for the Legal Work Group of the HISPC was to develop model documents and forms for possible use by state-level HIEs, clinicians, health care facilities and other providers.

In accordance with that tasks, the Legal Work Group considered the legalities associated with the use and disclosure of health information in an HIE and developed three (3) model forms to assist health care providers, participants and organizers of HIEs: (a) a Notice of Privacy Practices insert; (2) a form of Consent and Disclosure of Certain Types/Categories of Protected Health Information; and (3) a form of Authorization for Use and Disclosure of Protected Health Information for Research.

Notice of Privacy Practices Insert: The Notice of Privacy Practices insert would supplement a covered health care provider's current HIPAA Notice of Privacy Practices. The insert informs recipients that the provider participates in an HIE and the purpose of that HIE. The insert also notifies the recipient that the provider may disclose the patient's protected health information to other participants in the HIE for treatment, payment and health care operation purposes, but that the provider will seek the patient's consent or authorization, as necessary, before disclosing the patient's protected health information to other participants in the HIE.

Consent for Use and Disclosure of Certain Types/Categories of Protected Health Information. In certain cases, federal or state law may obligate a provider to obtain a patient's written consent before disclosing the patient's protected health information, even if that disclosure is for treatment, payment or health care operation purposes. The sample consent form facilitates that disclosure and can be used in conjunction with the HIE or otherwise.

Authorization for Use and Disclosure of Protected Health Information for Research. If a covered entity health care provider intends to use or disclose a patient's protected health information for research, the patient's authorization may be required under the HIPAA Privacy Rule and operative state or federal law. The sample authorization form addresses the use and disclosure of protected health information for research purposes.

Notices of Privacy Practices Insert

To be used in conjunction with an Authorization to disclose "sensitive" health information. Presumes legal authority to otherwise disclose PHI for treatment, payment or health care operation purposes.

[PROVIDER] also participates in a health information exchange (Exchange). The Exchange facilitates the electronic exchange of medical and other protected health information among health care providers that participate in the Exchange for patient treatment, payment and health care operation purposes. If applicable, add: "The Exchange does not house or store any data; rather, it merely facilitates exchange of data among participating health care providers."

To the extent permitted by law, [PROVIDER] may disclose your protected health information to other health care providers who request that information, via the Exchange. In those cases where your specific consent or authorization is required to disclose health information to others, [PROVIDER] will not disclose that health information to other health care providers participating in the Exchange without first obtaining your written consent.

CONSENT FOR USE AND DISCLOSURE OF CERTAIN TYPES/CATEGORIES OF PROTECTED HEALTH INFORMATION

PURPOSE AND INSTRUCTIONS:

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HIPAA Privacy Rule authorize us to use and disclose your Protected Health Information, without your authorization or consent, for treatment, payment and health care operations activities. However, in certain situations we may need your prior written consent in order to disclose certain categories/types of Protected Health Information under other state or federal laws. We will not deny you treatment or care if you refuse to sign this Consent, but we may not be able to share all of your relevant health information with other health care providers involved in your treatment and care. If you agree to allow us to disclose some or all of the requested Protected Health Information, please complete and sign this Consent.

(Please Print Legibly)

<table>
<tr><td colspan="2">Patient Name (Last, First, Middle)</td><td colspan="2">Medical Record Number</td></tr>
<tr><td colspan="2">Street Address</td><td colspan="2">SSN or other ID (Please indicate other by name)</td></tr>
<tr><td>City</td><td>State</td><td>Zip Code</td><td>Telephone</td></tr>
</table>

I, _____[Your Name], authorize _____ (the "Provider") to disclose the Protected Health Information specified below to _____[Identify recipient]

[If the recipient is intended to be health care providers in the health information exchange, then insert the following language above—other health care providers, including but not limited other health care providers participating in the health information exchange ("Exchange") who may request such information for treatment, payment and health care operation purposes. The Exchange facilitates the electronic exchange of medical and other individually identifiable health information among health care providers that participate in the Exchange for patient treatment, payment and health care operations].

[*For use with the Exchange:* I understand the purpose of the electronic disclosure of my medical and health information to other health care providers that participate in the Exchange is to facilitate my medical treatment (both primary and specialty care), arrange for payment for health care services provided to me and for other administrative purposes by the participants in the Exchange]. I understand the information to be disclosed includes the medical [and billing] records used to make decisions about me. For example, my record may include the following kinds of Protected Health Information:

- Demographic (name, age, address, etc.);
- Medical (diagnosis, treatment history, referrals to other providers, *etc.*); and,
- Encounter Data (description of services provided).\

EXCEPT AS OTHERWISE PERMITTED OR REQUIRED BY ILLINOIS LAW (E.G., FOR PUBLIC HEALTH REPORTING PURPOSES), YOU MUST INITIAL EACH OF THE FOLLOWING CATEGORIES/TYPES OF PROTECTED HEALTH INFORMATION THAT YOU AUTHORIZE US TO DISCLOSE FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION PURPOSES:

_____ Alcohol Treatment Records (please initial) (Your consent to disclose is valid for one (1) year from the date of date of this Consent)
_____ Drug Abuse Treatment Records (please initial) (Your consent to disclose is valid for one (1) year from the date of date of this Consent)
_____ Mental Health and Developmental Disability Treatment Records (please initial)(Your consent to disclose is valid for one (1) year from the date of date of this Consent)
_____ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records (please initial)
_____ Hepatitis B or C Testing Records (please initial)
_____ Genetic Testing Records (please initial)

REVOCATION

I understand that I may revoke this Consent, in whole or in part, by sending a written and dated notice to the Provider. Notice of your revocation of this Consent should be sent to:

_____
_____
_____

Your revocation of this Consent will not affect any disclosures made prior to the acceptance of your revocation by Provider and you hereby acknowledge that Provider is released from any and all responsibility or liability for disclosure of the above information to the extent indicated and authorized by this Consent prior to Provider's acceptance of its revocation.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED TO PERMIT DISCLOSURE

I understand the purpose of the Network/Exchange and this Consent and agree to the disclosure of my medical and health information as set forth herein.

Signature Date

Authority of Personal Representative (if applicable):_____

Identify Verified by: ☐ Photo ID, ☐ Matching Signature, ☐ Other, Specify

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR RESEARCH

PURPOSE AND INSTRUCTIONS:

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HIPAA Privacy Rule authorize us to use and disclose your Protected Health Information, without your authorization or consent, for treatment, payment and health care operations activities. However, we may need your written authorization in order to use and disclose your Protected Health Information for some research activities. We will not deny you treatment or care if you refuse to sign this Authorization, however, if you do not sign this Authorization you will not be able to participate in the research study described below. If you agree to allow us to use and disclose your Protected Health Information for research, please complete and sign this Authorization.

(Please Print Legibly)

Patient Name (Last, First, Middle)		Medical Record Number	
Street Address		SSN or other ID (Please indicate other by name)	
City	State	Zip Code	Telephone

I, _____[Your Name], authorize _____ (the "Provider") to use and to disclose the Protected Health Information specified below to _____ [Identify recipient]

[*If the recipient is intended to be health care providers participating in the health information exchange, then insert the following language above*—other health care providers, including but not limited other health care providers participating in the health information exchange ("Exchange") who may request such information for research purposes and I hereby specifically authorize Provider to release my Protected Health Information to the Exchange and researchers for that purpose].

Protected Health Information to be Disclosed: Specifically and meaningfully describe the Protected Health Information authorized to be disclosed for research:

_____

My authorization to disclose Protected Health Information for research purposes specifically includes the disclosure of the following categories/types of Protected Health Information . **UNDER ILLINOIS LAW, YOU MUST INITIAL EACH OF THE FOLLOWING CATEGORIES/TYPES OF PROTECTED HEALTH INFORMATION THAT YOU AUTHORIZE US TO DISCLOSE FOR RESEARCH**:

_____ Alcohol Treatment Records (please initial) (Your authorization to disclose is valid for one (1) year from the date of date of this Authorization)
_____ Drug Abuse Treatment Records (please initial) (Your authorization to disclose is valid for one (1) year from the date of date of this Authorization)
_____ Mental Health and Developmental Disability Treatment Records (please initial) (Your authorization to disclose is valid for one (1) year from the date of date of this Authorization)
_____ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records (please initial)
_____ Hepatitis B or C Testing Records (please initial)
_____ Genetic Testing Records (please initial)

EXPIRATION

Except as otherwise specifically provided above, my authorization to use my Protected Health Information for research and to disclose my Protected health Information to other health care providers in the Network for research is valid for the for the time period between _____ (date) and _____ (date/event).

RE-DISCLOSURE

I understand that, except as otherwise specifically prohibited by Illinois or federal law, the Protected Health Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 or its implementing regulations. Participants in the Exchange, including Provider, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

REVOCATION

I understand that I may revoke this Authorization, in whole or in part, by sending a written and dated notice to the Provider. Notice of your revocation of this Authorization should be sent to:

_____
_____
_____

Your revocation of this Authorization will not apply to any uses and disclosures made prior to the acceptance of your revocation by Provider and you hereby acknowledge that Provider is released from any and all responsibility or liability for disclosure of the above information to the extent indicated and authorized by this Authorization prior to Provider's acceptance of its revocation.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED TO PERMIT DISCLOSURE

I understand the purpose of this Authorization and agree to the disclosure of my medical and health information for research as set forth herein.

Signature Date

Authority of Personal Representative (if applicable):_____

Identify Verified by: ☐ Photo ID, ☐ Matching Signature, ☐ Other, Specify _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.