

**HIPAA Privacy Policy #10**  
**Consent and Authorization to Use or Disclose Protected Health Information**

Effective Date: January 22, 2020	Refer to Privacy Rule Sections: 164.501; 164.502; 164.506; 164.508; 168.510; 164.512; 164.530
Authorized by: Equinox Board of Directors	Version #:

**Policy:** Equinox, Inc. will comply with the requirements set forth regarding authorizations and shall obtain consent for the use and disclosure of Protected Health Information for treatment, payment and health care operations.

**Purpose:** HIPAA requires Equinox, Inc. to obtain an authorization to use or disclose Protected Health Information, except in certain circumstances. HIPAA makes obtaining patient consent for a use or disclosure of Protected Health Information for treatment, payment and health care operations purposes optional. New York, however, requires such a consent and best practice would always be to obtain written consent. Equinox, Inc. has created the following policies and procedures and documents to comply with applicable laws and regulations.

**Procedures / Responsibilities:**

1. **Obtain Consent:** Equinox, Inc. shall obtain a patient's Consent from every patient who receives treatment from Equinox, Inc.. Equinox, Inc. shall endeavor to obtain a patient's Consent *prior to providing any services to the patient* by having the patient sign Equinox, Inc.'s "Consent." However, in cases of emergencies or when the patient is otherwise unable to provide his or her Consent, Equinox, Inc. shall obtain the patient's Consent as soon as possible following treatment of the patient. *N.Y. Education Law § 6530(23)*.
  - a. **Effect of Failure to Obtain Consent:** If Equinox, Inc. does not obtain a patient's Consent, Equinox, Inc. will not disclose any information that identifies a patient without the patient's specific written Authorization or as specifically permitted or required by law.
2. **Obtain Authorization:** Equinox, Inc. shall obtain Authorization to use and disclose a patient's Protected Health Information that are not otherwise permitted or required under HIPAA and New York State Law. *See* Equinox, Inc.'s Policy Nos. 10 through 15 regarding the Uses and Disclosure of Protected Health Information.
3. **Consent and Authorization Content:** Consent language and authorization forms for the disclosure of Protected Health Information will be written in plain language and will contain the following:
  - a. **Required Elements:**
    - i. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
    - ii. A description of each purpose of the requested use or disclosure;
    - iii. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
    - iv. The name or other specific identification of the person(s), or class of persons, to whom Equinox, Inc. may make the requested use or disclosure;

- v. An expiration date or an expiration event that relates to the patient or the purpose of the use or disclosure;
- vi. A statement of the patient's right to revoke the authorization in writing and the exceptions to the right to revoke;
- vii. A description of how the patient may revoke the authorization;
- viii. A statement that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by law;
- ix. The signature of the patient or signature of the personal representative with a description of the personal representative's authority to act for the patient, and date;
- x. A statement that the patient may inspect or copy the Protected Health Information to be used or disclosed;
- xi. A statement that the patient may refuse to sign the authorization;
- xii. If applicable, a statement that the use or disclosure of the requested information will result in direct or indirect remuneration to Equinox, Inc. from a third party; and
- xiii. A statement that Equinox, Inc. will not condition treatment, payment, or eligibility for benefits on the patient providing authorization for the requested use or disclosure.

4. Authorization Form:

- a. Complete Equinox, Inc.'s Authorization Form: If Equinox, Inc. intends to disclose Protected Health Information to a third party with an Authorization, Equinox, Inc. must ensure that the Authorization is HIPAA compliant, and properly completed. The Office of Court Administration provides a form (*See Attachment 1*), entitled "Authorization for Release of Health Information Pursuant to HIPAA," OCA Form 960, and the New York State Department of Health provides a form, (*See Attachment 2*), entitled "HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV\* Related Information," DOH Form 2557. The OCA form is intended to allow release of Protected Health Information to an attorney or government agency. Equinox, Inc. shall accept a properly completed OCA Form 960 for release of Protected Health Information to an attorney or governmental agency. The New York State Department of Health form is intended for the release of Protected Health Information to a facility or a patient. Equinox, Inc. shall accept a properly completed DOH Form 2557 for release of Protected Health Information to a facility or patient. *See attached OCA Form and DOH Form 2557.*
- b. Ensure Third-Party Authorizations are Appropriate: Equinox, Inc. should endeavor to use the OCA form, the DOH form or Equinox, Inc.'s standard Authorization when an Authorization is required. However, if Equinox, Inc. receives a request for records in the form of an Authorization created by a third-party, Equinox, Inc. must ensure that the third-party Authorization contains the elements contained in Section 2 herein.

*See Attachment 3* entitled "Checklist For Reviewing Third-Party Authorizations."

---

\* Human Immunodeficiency Virus that causes AIDS.

- c. Authorization Not Effective: An Authorization signed by a patient shall not be effective if:
  - i. The expiration date has passed, or the expiration event is known by Equinox, Inc. to have occurred;
  - ii. The Authorization has not been filled out completely;
  - iii. Equinox, Inc. is aware that the Authorization has been revoked;
  - iv. The Authorization violates the conditions for allowable use of a compound or combined authorization;
  - v. Equinox, Inc. knows that the information on the Authorization is false; or
  - vi. The Authorization lacks a required element.
  
- 5. Revocation of Authorizations: A patient or a patient's personal representative may revoke an Authorization at any time by providing a written and signed revocation to Equinox, Inc.. If Equinox, Inc. receives a revocation, Equinox, Inc. must attach the revocation to the original Authorization and destroy all copies of the original Authorization. The revocation shall be placed in the patient's medical record. Equinox, Inc. must notify its Business Associates who previously received copies of the original Authorization that the Authorization is no longer valid. *45 C.F.R. 164.508(b)(5)*. The revocation is not effective to the extent that Equinox, Inc. has already taken action in reliance on the Authorization.
  
- 6. Authorization Not Required:
  - a. Public Policy Purposes: Equinox, Inc. does not require a patient's Authorization to Use or Disclose Protected Health Information for any purpose described in Equinox, Inc.'s Policies Nos. 17 through 28 (such as disclosures relating to Public Health Activities, Law Enforcement Activities, Subpoenas, Court Orders, Business Associates, and Workers' Compensation Purposes). However, Equinox, Inc. may require an Authorization to disclose certain information for Public Policy Purposes as described in the subsequent section. *45 C.F.R. 164.512*.
  
- 7. Disclosures for Which There is an Opportunity to Agree or Object:
  - a. Some uses and disclosures do not require an authorization so long as Equinox, Inc. provides the patient with the opportunity to agree or object. These include:
    - i. Persons involved in the patient's care. Equinox, Inc. may disclose to a family member, other relative, or a close personal friend of the patient, or any other person identified by the patient, the Protected Health Information directly relevant to such person's involvement with the patient's care or payment related to the patient's health care;
    - ii. Notifications about the patient. Equinox, Inc. can notify a family member, a personal representative of the patient, or another person responsible for the care of the patient regarding the patient's location, general condition, or death; and
    - iii. Disaster relief efforts. Equinox, Inc. may use or disclose Protected Health Information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts in order to coordinate such notification during a disaster.

*See* Equinox, Inc.'s Policy No. 16 entitled "Disclosures of Protected Health Information Without Patient Authorization to Family and Friends."

8. Minimum Necessary: The Minimum Necessary Rule does not apply to information that Equinox, Inc. uses or discloses pursuant to a patient's written Authorization. However, New York law generally requires that any disclosure of patient information must be limited to the information necessary in light of the reason for disclosure. *See* Equinox, Inc.'s Policy No. 7 entitled "Minimum Necessary Uses, Disclosures and Requests of Protected Health Information." 45 C.F.R. 164.502(b).
9. Special Protection for Highly Sensitive Protected Health Information: In accordance with certain Federal and New York State laws, Equinox, Inc. must provide greater privacy protections to highly sensitive Protected Health Information, which includes information that relates to HIV, Mental Health, Psychotherapy Notes, Alcohol and Substance Abuse Treatment, and Genetics. The Privacy Officer, and legal counsel when appropriate, should be consulted prior to the disclosure of such information. *See* Equinox, Inc.'s Policy No. 14 entitled "Uses and Disclosures of Highly Sensitive Protected Health Information."

## Attachment 1

### Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act (“HIPAA”) and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as “at the conclusion of my court case” or provide a specific date amount of time, such as “3 years from this date.”

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.



Attachment 1

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Table with 3 columns: Patient Name, Date of Birth, Social Security Number; Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996

(HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV\* RELATED INFORMATION only if place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information:
8. Name and address of person(s) or category of person to whom this information will be sent:
9(a). Specific information to be released:
[ ] Medical Record from (insert date) to (insert date)
[ ] Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
[ ] Other:
Include: (Indicate by Initialing)
Alcohol/Drug Treatment
Mental Health Information
HIV-Related Information
Authorization to Discuss Health Information
(b) [ ] By initialing here I authorize
Initials Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
(Attorney/Firm Name or Governmental Agency Name)
10. Reason for release of information:
[ ] At request of individual
[ ] Other:
11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:
13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law.

\* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Attachment 2

**Authorization for Release of Health Information  
and Confidential HIV-Related Information\***

New York State Department of Health

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

- I consent to disclosure of (please check all that apply):
- My HIV-related information
  - My non-HIV health information
  - Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related information: _____ _____
Name of person whose information will be released: _____
Name and address of person signing this form (if other than above): _____ _____
Relationship to person whose information will be released: _____
Describe information to be released: _____
Reason for release of information: _____
Time Period During Which Release of Information is Authorized: From: _____ To: _____
Exceptions to the right to revoke consent, if any: _____ _____
Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences) _____ _____
Please sign below <b>only</b> if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.
Signature _____ Date: _____

\* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.

**Authorization for Release of Health Information  
and Confidential HIV-Related Information\***

---

**Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general health and/or HIV-related information:

---

---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

---

---

Name and address of facility/person to be given general health and/or HIV-related information:

---

---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

---

---

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If legal representative, indicate relationship to subject:

Print Name \_\_\_\_\_

Client/Patient Number \_\_\_\_\_

\* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.

**Authorization for Release of Health Information  
and Confidential HIV-Related Information\***

---

**Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general health and/or HIV-related information:

---

---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

---

---

Name and address of facility/person to be given general health and/or HIV-related information:

---

---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

---

---

Name and address of facility/person to be given general health and/or HIV-related information.

---

---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

---

---

Signature _____	Date _____
If legal representative, indicate relationship to subject:	
Client/Patient Number _____	

---

\* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.

Attachment 3

**CHECKLIST FOR REVIEWING THIRD-PARTY AUTHORIZATIONS FOR RELEASE OF  
PROTECTED HEALTH INFORMATION**

**Every item below must be present in order for an authorization to be valid.**

- Does the authorization adequately identify the individual's record to be used or disclosed?
- Does the authorization contain a specific and meaningful description of the information to be used or disclosed?
- Does the authorization contain the name or other specific identification of the person(s) or class of persons authorized to make the requested use or disclosure?
- Does the authorization contain the name or other specific identification of the person(s) or class of persons to whom the requested use or disclosure may be made?
- Does the authorization contain a description of each purpose of the requested use or disclosure?  
Note: The statement "at the request of the individual" is a sufficient description of purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- Does the authorization contain an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure?
- Does the authorization contain the signature of the individual, or the individual's authorized representative, and the date? If the authorization is signed by an individual's personal representative, does the authorization contain a description of the representative's authority to act for the individual?
- Does the authorization discuss the right of the individual to revoke the authorization in writing?
- Does the authorization discuss the exceptions to the individual's right to revoke or reference the fact that such exceptions are contained in the third-party's Notice of Privacy Practices?
- Does the authorization contain a statement that the third party cannot condition the provision of treatment, payment, enrollment or eligibility for benefits on the individual signing the authorization?
- Does the authorization contain a statement discussing the potential for the information disclosed pursuant to the authorization to be redisclosed by the recipient and that such information will no longer be protected?
- Is the authorization written in plain language that is generally understandable?
- If the authorization is for Protected Health Information related to HIV/AIDS, drug/alcohol abuse, or mental health/psychiatric disorders, does the authorization specifically authorize the release of such information?