	Ethics & Compliance Department		
	Policy No.: 36	**Created:**	01/2018
		Reviewed:	06/2025
		Revised:	06/2025

HIPAA: GENERAL REQUIREMENTS FOR DISCLOSURE OR RELEASE OF INFORMATION AND AUTHORIZATIONS

SCOPE:

All Envision Healthcare teammates. For purposes of this policy, all references to "teammate" or "teammates" include temporary, part-time and full-time employees, independent contractors, clinicians, officers and directors.

PURPOSE:

Envision Healthcare Operating, Inc. and its subsidiaries and affiliates ("Envision" or "the Company") has adopted this General Requirements for Disclosure or Release of Information and Authorizations policy to define the process requirements for disclosing PHI.

POLICY:

Disclosure or Release of Information

The process of disclosure will vary based on the content of the information and the circumstances surrounding the disclosure.

1) In general, the Company will disclose a patient's PHI to any person, entity, or company only:
    a. After verification that the disclosure is authorized by the treatment, payment, or operations definitions of the Privacy Regulations;
    b. The disclosure is to a bona fide Business Associate;
    c. The disclosure is to the patient him/herself; or
    d. A valid authorization has been received.
2) The department may use or disclose PHI without prior written consent under the following circumstances:
    a. If the Company has an indirect treatment relationship with the patient;
    b. In emergency treatment situations;
    c. If required by law; or
    d. If the patient's consent to receive treatment is clearly inferred from the

circumstances.

3) The Company will not disclose an entire medical record except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure, or request.
4) The Company will release information that was received or created outside the process of providing treatment, payment, or health care operations, only with direct authorization from the patient. When releasing information based on a patient authorization, the department will only disclose information consistent with terms of the authorization.
5) The Company will take reasonable steps to verify the identity and authority of the individual or organization to which PHI is disclosed. Reasonable steps may include a request to see positive identification of a person (e.g., driver's license or other government issued photo identification) or through information that would only be known to an authentic personal representative (e.g., social security number – last four digits, date of birth, telephone number, maiden name, spouse's name).

Authorizations

The Company will not use or disclose PHI that was received or created outside the process of providing treatment, payment, or health care operations, without an authorization from the patient unless an exception is met. When the Company obtains or receives a valid authorization for its use or disclosure of PHI, such use or disclosure must be consistent with such authorization.

1) The authorization must include the following elements:
    a. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
    b. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
    c. The name or other specific identification of the person(s), or class of persons, to whom the Company may make the requested use or disclosure;
    d. An expiration date or an expiration event that relates to the patient or the purpose of the use or disclosure;
    e. A statement of the patient's right to revoke the authorization in writing and the exceptions to the right to revoke, together with a description of how the patient may revoke the authorization;

f. A statement that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule;
g. Signature of the patient and date; and
h. If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient.

See "Authorization to Release Health Information," form attached below.

2) An authorization is not valid, if the document submitted has any of the following defects:
   a. The expiration date has passed, or the expiration event is known by the covered entity to have occurred;
   b. The authorization has not been filled out completely;
   c. The authorization has been revoked;
   d. The authorization does not contain all the required elements as defined in this policy;
   e. Any material information in the authorization is known to be false.
3) The Company will not condition treatment on the provision of an authorization, except that the Company may condition the provision of "research-related" treatment on provision of an authorization.
4) The Company may also condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. For example, the Company may have a contract with an employer to provide fitness-for-duty exams, or a contract with a life-insurer to provide pre-enrollment physicals for applicants. In each of these cases, the Company would condition the health care services on provision of an authorization.
5) The Company will allow a patient to revoke an authorization at any time, provided that the revocation is in writing, except to the extent that the Company has taken action in reliance thereon.

POLICY REVIEW

The Ethics & Compliance Department will review and update this Policy, when necessary, in the normal course of its review of the Company's Ethics & Compliance Program.

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name:

Patient Address:

Date of Birth (mm/dd/yyyy): Patient's Phone:

Other Identifier (Last 4 digits of Social Security #):

I AUTHORIZE _____

TO DISCLOSE MY HEALTH INFORMATION TO: _____

Name of person or organization:

To the Attention of:

Street Address of Entity:

City: State: Zip: Phone or Email of Recipient:

Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ *(insert dates)*:

☐ The following medical records:

❑ Discharge summary	❑ Progress notes
❑ Lab results	❑ Photographs, videotapes, or other images
❑ History and physical exam	❑ Mental or behavioral health records
❑ Consultation reports	❑ Psychotherapy notes
❑ X-ray reports	❑ Genetic test results
❑ HIV/AIDS test results and treatment	❑ Entire medical record
❑ Alcohol and drug treatment records	❑ Summary of treatment
❑ Operative record	❑ Other (specify):

☐ The following billing and payment information:

_____

_____

☐ Other information: _____

_____

REASON FOR REQUESTED USE OR DISCLOSURE:

TO BE READ AND SIGNED BY PATIENT OR LEGAL REPRESENTATIVE:

I understand the following:

a. I may revoke this authorization at any time by providing written notice.
b. I may not be able to revoke this authorization if the company has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. I understand that I may refuse to sign this Authorization and that the company will not condition treatment on whether I sign this Authorization.
d. I am signing this authorization freely and no one has pressured me to sign this authorization.
e. The information disclosed in this authorization may be subject to re-disclosure by the receiving party and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
g. Expiration: I understand that unless I revoke the authorization earlier, this authorization will automatically expire one (1) calendar year after the date this authorization is signed.

Patient Signature: Date:

Signature of Patient's Representative: Relationship: Date:

FOR OFFICE USE ONLY:

Event or Date Upon Which Authorization Will Expire:

If no date is specified, this authorization will expire within 1 year of the date above.