Department of Veterans Affairs

Memorandum

Date: March 17, 2003

VAOPGCADV 3-2003

From: General Counsel (02)

Subj: Health Insurance Portability and Accountability Act Applicability in VBA

To: Director, Compensation and Pension Service (21)

QUESTION: Whether the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule applies to Veterans Benefits Administration (VBA).

DISCUSSION:

BACKGROUND

1. You asked the Office of General Counsel thirty four questions concerning the application of the privacy provision of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act [PUB. L. NO. 104-191, Title II, Subtitle F (§§ 261-64) (1996)], to VBA, particularly the Compensation and Pension (C &P) Service.

2. Section 264(c)(1) of the HIPAA tasked the Department of Health and Human Services (HHS) with promulgating standards to protect the privacy of individually identifiable health information as defined in 42 U.S.C. § 1320d(6). HHS promulgated the standards, with subsequent amendments, in regulations located at 45 C.F.R. Parts 160 and 164, commonly referred to as the Privacy Rule. 65 Fed. Reg. 82462-82829 (2000), as amended by 67 Fed. Reg. 533182-273 (2002).

COVERED ENTITIES

3. In the first paragraph of the 2000 Federal Register notice, HHS stated that the Privacy Rule applies to "health plans, health care clearinghouses, and certain health care providers." See also § 160.102, and §§164.104, 164.106, 164.500. The Privacy Rule refers to these collectively as covered entities. 45 C.F.R. § 160.103. The threshold question then is whether VBA constitutes a covered entity.

4. A health plan provides, or pays the cost, of medical care, as the term medical care is defined in 42 U.S.C. § 300gg–91(a)(2). 42 U.S.C. § 1320d (5). Medical care in the pertinent part of that subsection, refers to diagnosis, cure, mitigation, treatment, or prevention of disease, and the affecting of any structure or function of the body.

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5. A health care clearinghouse is referred to as an entity which translates health information from one format to another and forwards it, (42 U.S.C. § 1320d (2)), and is not relevant for this opinion.

6. A health care provider is defined under 42 U.S.C. § 1320d (3) as:

- a provider of services as defined in 42 U.S.C. § 1395x(u), i.e., hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, and hospice programs;
- a provider of medical or health services as defined in 42 U.S.C. § 1395x(s), e.g., physicians' services, office-type services and supplies furnished incident to a physician's professional service, diagnostic tests, therapy, dressings and casts, durable medical equipment, ambulance service, prosthetic devices, vaccine, nurse anesthetist services, and mammography and other types of screening or
- anyone else who furnishes, bills or is paid for health care in the normal course of business.

7. The Privacy Rule defines health care as care, services, or supplies related to the health of an individual. Health care includes but is not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, *assessment*, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function or the body, and dispensing of an item in accordance with a prescription. 42 C.F.R. § 160.103; italics supplied. The term "assessment" was added to the definition when the final rule was adopted in December 2000. Explanatory regulatory material published with the change stated "assessments are conducted in the initial step of diagnosis and treatment of a patient. If assessment is not included in the list of services, the services provided by occupational health nurses and employee health information may not be covered." 65 Fed. Reg. 82572 (2000).

8. Given the functions and activities set forth above, it seems clear that certain components of VBA are not covered entities: Education Service, Loan Guaranty Service and Insurance Service.[1] Similarly, most activities of C & P Service are not of the type listed above for covered entities. However, since a C & P examination could arguably fall under the definition of "health care," and thus possibly be deemed an activity of a "health care provider," we will examine this activity in more detail before characterizing C & P Service.

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[1] We will consider whether any activities of Vocational Rehabilitation and Employment Service constitute covered entity activities in a subsequent memorandum opinion.

9. As indicated above, under the Privacy Rule definition an entity may be a covered health care provider if it engages in the performance of an "assessment . . . with respect to the physical or mental condition, or functional status, of an individual." C & P examinations are intended to, and do, provide evaluations of the physical or mental status of applicants for VA benefits. However, the quoted language appears to contemplate a meaning and purpose quite different from a C & P type of assessment. The statutory and regulatory definitions of health plan and health care provider include the following terms to describe their health care activities: diagnosis, diagnostic, test, screening, care, treatment, therapeutic, therapy, anesthetist services, vaccine, dressings, supplies, equipment, cure, mitigation, rehabilitative, maintenance, palliative and preventive. The common denominator of these many terms is the focus on active intervention for the purpose of affecting the health status of an individual. Evaluation or "assessment" of the individual's condition in the context of these many terms is clearly for the purpose of selecting a course of action to improve that condition.

10. The December 2000 comment of HHS explaining why "assessment" was added corroborates such an understanding when it identifies "assessment" as an early step in the diagnosis and treatment of a patient. In contrast, while a C & P examination may constitute an "assessment" of the physical or mental condition of a VA beneficiary, it is not for therapeutic intervention. The C & P examination is to assess for the entirely different purpose of compensating an individual monetarily or otherwise for a loss of physical or mental function. Since the purpose of this assessment is not care and treatment, we conclude that the performance of this examination activity does not constitute "health care," and thus falls outside the scope of the activities of covered entities.

11. Accordingly, we conclude that C & P Service is not a covered entity and that the HIPAA Privacy Rule does not apply to VBA C & P examination records. It follows that when a third party entity performing C & P examinations on behalf of VBA, including VHA, creates such records, they are not protected by the Privacy Rule.

PROTECTED HEALTH INFORMATION HELD BY NON-COVERED ENTITIES

12. The Veterans Health Administration (VHA) is designated a health plan as to care provided or paid for under Chapter 17 of title 38, United States Code. 42 U.S.C. § 1320d(5)(J). VHA's treatment activities also satisfy the definition of a covered health care provider. 42 U.S.C. § 1320d(3); 45 C.F.R. § 160.103. Consequently individually identified health information created or maintained by VHA for VHA purposes, (as opposed to VBA purposes as discussed above), is protected from use or disclosure not authorized by the Privacy Rule. On the other hand, since VBA is not a covered entity, the Privacy Rule does not apply to

protected individually identifiable health information once it is received by VBA (with the possible exception of Vocational Rehabilitation and Employment Service). HHS agreed with that conclusion when it determined that it lacks authority under HIPAA to make the Privacy Rule applicable to non-covered entities. HHS summarized this analysis when it said:

> [O]ur jurisdiction under the statute is limited to health plans, health care clearinghouses, and health care providers who transmit any health information electronically in connection with any of the standard financial and administrative transactions in section 1173(a) of the Act [the Social Security Act]. These are the entities referred to in section 1173(a)(1) of the Act and thus listed in 160.103 of the final rule. Consequently, *once protected health information leaves the purview of one of these covered entities, their business associates, or other related entities (such as plan sponsors), the information is no longer afforded protection under this rule.*

65 Fed. Reg. 82567; italics supplied.

A SPECIAL VA EXCEPTION: DISCLOSURE FOR ELIGIBILITY PURPOSES

13. A disclosure of protected health information by a covered entity to another entity is generally not permitted without a prior written authorization or an exception provided by the Privacy Rule. 45 C.F.R. § 164.502. The Privacy Rule provides an exception that *generally* permits VHA to provide protected health information to VBA for claim adjudication and benefits delivery purposes. 42 C.F.R. § 164.512(k)(1)(iii) states:

> A covered entity that is a component of the Department of Veterans Affairs may use and disclose protected health information to components of the Department that determine eligibility for or entitlement to, or that provide, benefits under the laws administered by the Secretary of Veterans Affairs.

Not covered by this exception, however, are psychotherapy notes and any protected health information, which is being disclosed for marketing (generally, communications to encourage the purchase or use of a product or service). 45 C.F.R. § 164.508. Psychotherapy notes will be discussed in detail in a subsequent opinion. Thus, except for psychotherapy notes and marketing efforts, individually identifiable health information may be provided by VHA to VBA to determine eligibility for, or entitlement to, or provide benefits under laws administered by the Secretary of Veterans Affairs without need for a written authorization. Moreover, as stated above, once it becomes VBA information, it is

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no longer subject to the protected health information requirements of the HIPAA Privacy Rule.

SUMMARY

14. We have applied the conclusions set out in this opinion to many of your specific questions; see Addendum, attached. It should be recalled, however, the individually identifiable health information once in VBA's possession is not unprotected. As you know, it continues to be protected by Federal statutes, such as the Privacy Act, 5 U.S.C. § 552a, 38 U.S.C. § 7332 where applicable, and 38 U.S.C. § 5701(a). As is currently the rule, VBA may use and disclose individually identifiable health information only as authorized by these statutes. We have not set forth this qualification to the answers that follow to avoid repetition. Nevertheless, these provisions must always be considered in the circumstances presented by your questions.

15. If you have any further questions about the answers provided in this memorandum, please contact Jeff Corzatt at 273-6362.

HELD:

VBA, with the possible exception of Vocational Rehabilitation and Employment Service (which will be considered in a subsequent opinion), is not subject to the HIPAA Privacy Rule.

Except for psychotherapy notes and disclosures for the purpose of marketing, health care information protected by the HIPAA Privacy Rule may be disclosed to VBA by VHA without written authorization if such disclosure is for the purpose of determination of eligibility for or entitlement to benefits or for the administration of benefits. Once it is received by VBA, it is no longer covered by the Privacy Rule. The information may still be protected by the Privacy Act and the VA confidentiality laws (38 U.S.C. §§ 5701(a), 7332), however.

Compensation and Pension examination reports prepared for VBA by VHA or any other entity, such as a contractor, are not covered by the Privacy Rule since that entity is acting as an agent of a noncovered entity in preparing such reports.

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ADDENDUM

ANSWERS TO SPECIFIC QUESTIONS ABOUT THE APPLICATION OF THE HIPAA PRIVACY RULE

Set forth immediately below are answers to most of the questions that VBA asked concerning the application of the HIPAA Privacy Rule. These answers apply only to activities of VBA. They do not apply to the Veterans Health Administration. As the remainders of the questions are resolved, we will provide the answers in subsequent memoranda. (An explanation rather than a question was presented under QUESTION 1.)

QUESTION 2: Does protected health information generated elsewhere retain that protection after transfer to VBA?
ANSWER: No.

QUESTION 3: What obligations, if any, does VBA have concerning the notice requirements of the Privacy Rule if it applies to protected health information provided to VBA?
ANSWER: VBA has no obligations concerning the notice requirements of the Privacy Rule.

QUESTION 4: Are there any new obligations if it does not?
ANSWER: No.

QUESTION 5: Does HIPAA impose any added restrictions on access to or disclosure of information in VBA claims files beyond that which already exist under the Privacy Act or under our routine uses?
ANSWER: No.

QUESTION 6: Is a Rating Decision which discusses and documents the veteran's health and claimed disabilities a protected medical record under HIPAA?
ANSWER: No.

QUESTION 7: Is a C&P examination report a protected health record within the meaning of HIPAA? Does the answer depend on whether it is conducted by the Veterans Health Administration or by a private contractor?
ANSWERS: No. Not applicable.

QUESTION 8: Assuming that the answer to question five above is in the affirmative, VBA obtains disability examinations from both VHA and a private vendor who does more than 70,000 examinations per year. Currently that vendor is QTC Corporation and VBA is currently engaged in a rebid of the contract. In

light of that we have the following questions [questions omitted in light of the response].
ANSWER: This question is not applicable, since the answer to question five is "no."

QUESTION 13: Please clarify what constitutes a valid authorization and a defective authorization?
ANSWER: A valid authorization meets all the requirements specified in 45 CFR 164.508. (Attached) A defective authorization does not. VBA will not need a Privacy Rule authorization to disclose health information received from VHA or another covered entity. However, if VBA seeks health care information protected by the Privacy Rule from a covered entity other than VHA, a valid authorization from the VA beneficiary will be required, unless an exception to the Privacy Rule applies.

QUESTION 14: Does information gathered by a VA field examiner on the health of a beneficiary for whom a fiduciary has been appointed constitute a protected health record within the meaning of HIPAA?
ANSWER: No, information created or gathered by a VA field examiner, including information gathered from a covered entity, is not subject to the HIPAA Privacy Rule.

QUESTION 15: Does VA's current policy of recognizing a licensed attorney as a POA if the attorney asserts representation on his/her letterhead meet the requirements of HIPAA for purposes of providing access to protected health information?
ANSWER: Because medical information in the possession of VBA is not protected health information, the HIPAA requirements do not apply to access to such information by a licensed attorney when the information is maintained by VBA.

QUESTION 16: Does a request from a power of attorney (veterans service organization, agent or attorney) under the Privacy Act and/or Freedom of Information Act for records from a claims, vocational rehabilitation or guardianship file require a HIPAA compliant release for VA to release these documents? Or may VA release such documents if the request is made over the POA's own signature and on the individual's or organization's letterhead?
ANSWER: Because VBA is not generally subject to the HIPAA Privacy Rule, a HIPAA-compliant release is not required to release protected health information contained in a veteran's VBA records to the current holder of the veteran's POA. As indicated above, we will address the vocational rehabilitation records in a future opinion.

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QUESTION 17: Does the provision of information and access to a claims file to a POA constitute a disclosure that must be disclosed to the individual about whom the record relates and/or that must be documented and cataloged on a six year rolling basis as required by 45 CFR 164.528? Please explain the minimum information that must be contained in the notice to the individual and any time limit that may exist about notification. What is the minimum information that must be maintained on the rolling log? Must the rolling log be maintained in the VA folder or as a separate system of records or both?
ANSWER: These questions presume that the VBA claim file contains information protected by the Privacy Rule. Because the Privacy Rule does not apply to the claim file, the HIPAA requirements to account for disclosures do not apply.

QUESTION 18: We understand that HIPAA applies as long as records on an individual exist, even if that individual is deceased. How does this affect the ability of a survivor to file for benefits to include appointing a POA to represent them? Can the POA who is representing the survivor review records of the deceased? If so, under what conditions?
ANSWER: While the Privacy Rule does apply to the protected health information of decedents when maintained by a covered entity, the Privacy Rule does not apply to VBA records.

QUESTION 20: VA provides information to other federal, state and local governmental bodies in the course of business, often without a release from the beneficiary. [Examples deleted] Would these require us to get a new release form?
ANSWER: Since the Privacy Rule does not apply to VBA, it need not obtain a HIPAA-compliant authorization before making disclosures to other governmental entities.

QUESTION 24: 45 CFR 164.512(e)(1)(v)(B) says in part "(B) Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding." Please explain the applicability of this provision to the VA claims process? [rest of question deleted.]
ANSWER: Because the HIPAA Privacy Rule does not apply to VBA claim proceedings or records, this HIPAA Privacy Rule provision is inapplicable to the VA claims process.

QUESTION 25: Does the current [VA form] 21-4142 meet the requirements of HIPAA? If not, how should it be modified? Do we need a separate release for psychotherapy records?
ANSWER: In order for VBA to obtain protected health information from a covered entity pursuant to a prior written authorization of the patient, that authorization must meet the requirements of 45 CFR 164.508. Under that section of the Privacy Rule, a separate authorization is required for psychotherapy notes. Thus,

if VBA seeks medical information other than psychotherapy notes and psychotherapy notes from the same private sector covered health care provider, VBA will have to provide the provider with two authorizations. 45 CFR 164.508(b)(3)(ii). (If a more-restrictive state or Federal law applies to the medical information sought, as now, VBA would have to use an authorization that meets the requirements of the applicable law.)

QUESTION 26: Do the current P-22 Appointment of a Power of Attorney and P-22A Appointment of an Agent meet the requirements of HIPAA for purposes of providing access to claims files and guardianship files? If not how should the forms be modified?
ANSWER: The HIPAA Privacy Rule does not apply to the claim and guardianship files.

QUESTION 29: Does HIPAA require us or is it to our advantage to republish our routine uses prior to April 13, 2003?
ANSWER: Because the HIPAA Privacy Rule does not apply to the VBA systems of records subject to the Privacy Act, it does not require VBA to republish its systems of records notices. However, many VBA systems of records have not been republished in some time. For example, it would appear that VBA has not republished its system of records for Compensation and Pension claim file records, VA System of Records 58VA21/22 since 1976. See, e.g., the Federal Register notice at 63 Fed. Reg. 37941 (1998). Under 1999 guidance from the Office of Management and Budget and a Presidential Memorandum for the Heads of Executive Departments and Agencies, Federal agencies are to conduct a review of their systems of records, update them, and republish them where necessary. Accordingly, it would appear appropriate for VBA, regardless of the HIPAA Privacy Rule, to review, and as necessary, update and republish its Privacy Act systems of records notices, including routine uses.

QUESTION 30: We believe that the required compliance date for HIPAA is April 14, 2003. What sanctions, if any, exist for non-compliance with the various provisions of HIPAA and its implementing regulations?
ANSWER: The HIPAA Privacy Rule is inapplicable to VBA claim records.

QUESTION 31: May a veteran waive his HIPAA rights in a manner similar to that whereby a military retiree waives his/her right to retired pay to receive compensation in advance of the final decision on his/her claim?"
ANSWER: There is no authority under the HIPAA statute or Privacy Rule for an individual to waive his/her rights under the Rule. We note that the only "waiver" of rights provision in the Privacy Rule that we can identify is a temporary "suspension" of the right of access to medical information by participants in clinical research if certain conditions are met. 45 CFR § 164.524(a)(2)(iii).

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QUESTIONS 32-34 presume that the HIPAA Privacy Rule applies to VBA claim records.
ANSWERS: Since the Rule does not apply to these records, there is no need to answer these questions at this time.

disclosures. Except with respect to uses or disclosures that require an authorization under § 164.508(a)(2) and (3), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart.

(b) *Standard: Consent for uses and disclosures permitted.*

(1) A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.

(2) Consent, under paragraph (b) of this section, shall not be effective to permit a use or disclosure of protected health information when an authorization, under § 164.508, is required or when another condition must be met for such use or disclosure to be permissible under this subpart.

(c) *Implementation specifications: Treatment, payment, or health care operations.*

(1) A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.

(2) A covered entity may disclose protected health information for treatment activities of a health care provider.

(3) A covered entity may disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information.

(4) A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:

(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or

(ii) For the purpose of health care fraud and abuse detection or compliance.

(5) A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to another covered entity that participates in the organized health care arrangement for any health care operations activities of the organized health care arrangement.

§ 164.508 Uses and disclosures for which an authorization is required.

(a) *Standard: authorizations for uses and disclosures.*

(1) *Authorization required: general rule.* Except as otherwise permitted or required by this subchapter, a covered entity may not use or disclose protected health information without an authorization that is valid under this section. When a covered entity obtains or receives a valid authorization for its use or disclosure of protected health information, such use or disclosure must be consistent with such authorization.

(2) *Authorization required: psychotherapy notes.* Notwithstanding any provision of this subpart, other than the transition provisions in § 164.532, a covered entity must obtain an authorization for any use or disclosure of psychotherapy notes, except:

(i) To carry out the following treatment, payment, or health care operations:

(A) Use by the originator of the psychotherapy notes for treatment;

(B) Use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or

(C) Use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual; and

(ii) A use or disclosure that is required by § 164.502(a)(2)(ii) or permitted by § 164.512(a); § 164.512(d) with respect to the oversight of the originator of the psychotherapy notes; § 164.512(g)(1); or § 164.512(j)(1)(i).

(3) *Authorization required: Marketing.*

(i) Notwithstanding any provision of this subpart, other than the transition provisions in § 164.532, a covered entity must obtain an authorization for any use or disclosure of protected health information for marketing, except if the communication is in the form of:

(A) A face-to-face communication made by a covered entity to an individual; or

(B) A promotional gift of nominal value provided by the covered entity.

(ii) If the marketing involves direct or indirect remuneration to the covered entity from a third party, the authorization must state that such remuneration is involved.

(b) *Implementation specifications: general requirements.*

(1) *Valid authorizations.*

(i) A valid authorization is a document that meets the requirements in paragraphs (a)(3)(ii), (c)(1), and (c)(2) of this section, as applicable.

(ii) A valid authorization may contain elements or information in addition to the elements required by this section, provided that such additional elements or information are not inconsistent with the elements required by this section.

(2) *Defective authorizations.* An authorization is not valid, if the document submitted has any of the following defects:

(i) The expiration date has passed or the expiration event is known by the covered entity to have occurred;

(ii) The authorization has not been filled out completely, with respect to an element described by paragraph (c) of this section, if applicable;

(iii) The authorization is known by the covered entity to have been revoked;

(iv) The authorization violates paragraph (b)(3) or (4) of this section, if applicable;

(v) Any material information in the authorization is known by the covered entity to be false.

(3) *Compound authorizations.* An authorization for use or disclosure of protected health information may not be combined with any other document to create a compound authorization, except as follows:

(i) An authorization for the use or disclosure of protected health information for a research study may be combined with any other type of written permission for the same research study, including another authorization for the use or disclosure of protected health information for such research or a consent to participate in such research;

(ii) An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes;

(iii) An authorization under this section, other than an authorization for a use or disclosure of psychotherapy notes, may be combined with any other such authorization under this section, except when a covered entity has conditioned the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits under paragraph (b)(4) of this section on the provision of one of the authorizations.

(4) *Prohibition on conditioning of authorizations.* A covered entity may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization, except:

(i) A covered health care provider may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health

information for such research under this section:

(ii) A health plan may condition enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to an individual's enrollment in the health plan, if:

(A) The authorization sought is for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations; and

(B) The authorization is not for a use or disclosure of psychotherapy notes under paragraph (a)(2) of this section; and

(iii) A covered entity may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

(5) *Revocation of authorizations.* An individual may revoke an authorization provided under this section at any time, provided that the revocation is in writing, except to the extent that:

(i) The covered entity has taken action in reliance thereon; or

(ii) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

(6) *Documentation.* A covered entity must document and retain any signed authorization under this section as required by § 164.530(j).

(c) *Implementation specifications: Core elements and requirements.*

(1) *Core elements.* A valid authorization under this section must contain at least the following elements:

(i) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.

(ii) The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.

(iv) A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

(v) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.

(vi) Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.

(2) *Required statements.* In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

(i) The individual's right to revoke the authorization in writing, and either:

(A) The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or

(B) To the extent that the information in paragraph (c)(2)(i)(A) of this section is included in the notice required by § 164.520, a reference to the covered entity's notice.

(ii) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:

(A) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in paragraph (b)(4) of this section applies; or

(B) The consequences to the individual of a refusal to sign the authorization when, in accordance with paragraph (b)(4) of this section, the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.

(iii) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this subpart.

(3) *Plain language requirement.* The authorization must be written in plain language.

(4) *Copy to the individual.* If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.

§ 164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.

A covered entity may use or disclose protected health information, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure, in accordance with the applicable requirements of this section. The covered entity may orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure permitted by this section.

(a) *Standard: use and disclosure for facility directories.*

(1) *Permitted uses and disclosure.* Except when an objection is expressed in accordance with paragraphs (a)(2) or (3) of this section, a covered health care provider may:

(i) Use the following protected health information to maintain a directory of individuals in its facility:

(A) The individual's name;

(B) The individual's location in the covered health care provider's facility;

(C) The individual's condition described in general terms that does not communicate specific medical information about the individual; and

(D) The individual's religious affiliation; and

(ii) Disclose for directory purposes such information:

(A) To members of the clergy; or

(B) Except for religious affiliation, to other persons who ask for the individual by name.

(2) *Opportunity to object.* A covered health care provider must inform an individual of the protected health information that it may include in a directory and the persons to whom it may disclose such information (including disclosures to clergy of information regarding religious affiliation) and provide the individual with the opportunity to restrict or prohibit some or all of the uses or disclosures permitted by paragraph (a)(1) of this section.

(3) *Emergency circumstances.*

(i) If the opportunity to object to uses or disclosures required by paragraph (a)(2) of this section cannot practicably be provided because of the individual's incapacity or an emergency treatment circumstance, a covered health care provider may use or disclose some or all of the protected health information permitted by paragraph (a)(1) of this section for the facility's directory, if such disclosure is:

(A) Consistent with a prior expressed preference of the individual, if any, that is known to the covered health care provider;