Privacy Engineering

Health IT

Adrian Gropper, MD
CTO, Patient Privacy Rights
Interface to One Person’s Data
Diversity
Business Legal Technical
Business

- Treatment
- Payment
- Operations
- Research
- Public Health
- Law Enforcement
Privacy Risk Management for Federal Information Systems

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Legal

- Risk Management
- Safe Harbor
- Incident Response
- Dispute Resolution
- Cyber-insurance
Authorization to Disclose Protected Health Information/Medical Records

<table>
<thead>
<tr>
<th>Patient Name (please print):</th>
<th>Maiden or Other Name (please print):</th>
<th>Patient Date of Birth:</th>
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<table>
<thead>
<tr>
<th>Patient Address (please print):</th>
<th>Telephone (Area Code and Number):</th>
<th>Email address (please print):</th>
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<table>
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<tr>
<th>Medical Record Number:</th>
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<thead>
<tr>
<th>Name, address, and telephone number of Person(s) or Entity to whom this information will be sent. Please check if same as above:</th>
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<tbody>
<tr>
<td>Send to (please print):</td>
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<tr>
<td>Address (please print):</td>
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<tr>
<th>Telephone (Area Code and Number):</th>
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<tr>
<th>Check the name of the Center to disclose information or choose Other Healthcare Provider (specify):</th>
</tr>
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<tbody>
<tr>
<td>□ NYP/Columbia University Medical Center (NYP/Allen Hospital) □ NYP/Morgan Stanley Children's Hospital</td>
</tr>
<tr>
<td>□ NYP/Weill Cornell Medical Center □ NYP/Westchester Division □ NYP/Lower Manhattan</td>
</tr>
<tr>
<td>□ Other (Provide Name of Entity):</td>
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Specify Information to be released (medical records will not be released unless a date of service(s) is identified on this form): 

Medical Record from (insert date) ______________________ to (insert date) ______________________

- Hospital Admission
- Emergency Department
- Ambulatory Surgery
- Outpatient

Specify reports requested (i.e. Lab tests, Radiology Reports, Operative Reports, Discharge Summary, etc.):

Include (Indicate by Initialing below): Please note that the information will not be released if not initialed:

- Alcohol/Drug Treatment
- Mental Health Treatment (except psychotherapy notes)
- HIV/AIDS Related Information
- Genetic Testing Information

Please consider the environment. When possible, NewYork-Presbyterian will provide the information you requested electronically please check preference:

- CD/DVD
- Electronic Delivery

Patients with an active myNYP.org account can request electronic delivery via secure web patient portal at no cost. Please confirm and initial below:

- I have an active myNYP.org account and understand the medical record(s) I requested will be sent to myNYP.org account.
- If my medical record(s) cannot be delivered to myNYP.org account it will be mailed to the above-stated address on CD/DVD

Patient or Personal Representative Initial

The purpose(s) for which disclosure is authorized (check where applicable): □ Individual's request □ Medical Care □ Insurance □ Immunization □ Legal

Other (specify): ______________________

I, or my authorized representative, request that health information regarding my care and treatment at NewYork-Presbyterian Hospital (NYP) be disclosed as described on this form. I understand that:

- I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below.
- Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.
- Treatment and payment will be conditional on whether you sign this authorization. Signing is voluntary, however, if you refuse to sign NYP will not release your records.
- By my specifically authorizing the release of HIV/AIDS related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. 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.
- Alcohol/Drug Treatment-related information or confidential HIV/AIDS-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.
- I may revoke this authorization at any time by providing written notice to NYP except to the extent that action has already been taken based on this authorization.
- I understand that this Authorization will expire on: Date ______________________ (provide date if less than 1 year) or 1 year after being signed.

Signature of Patient/personal representative (e.g., legal guardian): ______________________ Date ______________________

If personal representative, print name and relationship to patient: ______________________

Witness or Notary: ______________________

Date: ______________________

538486 (07/14)
Technical

• User Managed Access (UMA)
• Consent Receipts
• Federation
• GitHub
• “Good Faith”
• Notice
asynchronous consent by RO drives RqP’s acc...through data associated with RPT
Privacy Engineering

- Brokers
- Pairwise Pseudonymity
- Biometrics
- Secure Elements
- Frameworks
- Audits / Blockchain
I. **EDI** (machine-2-machine, custom)

II. **Web Portals** (machine-2-human, ad-supported)

III. **Public API** (machine-2-machine, standard)
Personal Authorization Server