TEXAS
Department of
Human Services

COMMISSIONER
James R. Hine

April 11, 2003

To: Community Alzheimer's Resources and Education (CARE) Provider Agencies
Consumer Managed Personal Assistance Services (CMPAS) Provider Agencies
Special Services to Persons with Disabilities (SSPD) Provider Agencies, Region 7

Subject: Long Term Care (LTC)
Information Letter No. 03-04
Health Insurance Portability and Accountability Act (HIPAA) Information and Forms

The attached information relates to the privacy rule provisions in the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that authorizes new privacy protections for health information and new privacy rights for recipients. The Texas Department of Human Services (DHS), certain provider agencies, and medical practitioners must all comply with the privacy requirements as outlined below. You should find this information helpful as you attempt to meet these requirements. DHS has determined that the attached forms and brochures comply with the privacy rules.

1) Authorization to Release Medical Information (DHS Form 2076). This form may be used to authorize the release of medical information, when medical practitioners require an authorization from the client. This form is available at www.dhs.state.tx.us/providers/index.html#handbooks

2) HIPAA Privacy Notice (DHS Form 0401). You should send this form to each client you serve, beginning April 14, 2003. The Privacy Notice tells the client about their privacy rights, the duties of DHS to protect health information, and how DHS may use or disclose health information.

3) Explanation of Health Information Privacy Rights (DHS Form 0403). This form also should be shared with each client. The Form 0403 is a cover letter for the HIPAA Privacy Notice (DHS Form 0401). The letter provides an explanation of the HIPAA Privacy Notice and a brief summary of information.

DHS Forms 0401 and 0403 are available at:
http://www.dhs.state.tx.us/publications/index.html in the forms section.

4) Basic HIPAA Privacy Overview. All Region 7 SSPD, CMPAS, and CARE staff who perform case management or assessment activities should complete this training course by April 14, 2003 A paper copy of this training is attached. The training packet takes approximately 30 minutes to complete.

Please contact your contract manager for further information regarding this information letter: Contract managers should contact the following DHS staff for more information.

Maxcine Tomlinson regarding CARE at (512) 438-3169;
Stephen Schoen regarding CMPAS at (512) 438-2622; and
Sarah Hambrick regarding SSPD at (512) 438-2578.

Sincerely,

Signature on file

Becky Beechinor
Assistant Deputy Commissioner
Long Term Care Services

BB:ck

Attachments

Texas Department
of Human Services

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA

Form **2076**
April 2003

TO BE COMPLETED BY CLIENT / EL CLIENTE DEBE LLENAR ESTA SECCIÓN

Patient's Name / Nombre del paciente _____

It is necessary for DHS or a provider agency to verify your medical needs to determine your eligibility for services. When you sign this authorization, you are giving DHS or a provider agency your permission to contact your doctors, medical facilities, or other health care providers and get copies of your health information as indicated below. Your signature is required on this authorization form to determine your eligibility for services.

El Departamento de Servicios Humanos de Texas (DHS) o una agencia proveedora tiene que verificar sus necesidades médicas para determinar si llena los requisitos para los servicios. Al firmar esta autorización, usted da permiso al DHS o a la agencia proveedora para que se comunique con sus doctores, centros médicos u otros proveedores de atención médica y obtenga copias de su información médica como se indica más adelante. Su firma es necesaria en esta autorización para determinar si tiene llena los requisitos para los servicios.

I authorize / Yo autorizo a _____
Doctors, Medical Facilities, or other Health Care Providers / Doctores, centros médicos u otros proveedores de atención médica

to complete form / para que llene la forma _____ ,
Form Name / Nombre de la forma

and release the information to / y divulgue la información a _____ .
List DHS or Provider Agency / DHS o el nombre de la agencia proveedora

This authorization expires on / Esta autorización se vence _____
Enter a Date or Name an Event / Fecha o el nombre de un evento

_____ _____
Client or Personal Representative's Signature / Firma del Cliente o del Representante Personal **Date** / Fecha

If you are signing for the client, please describe your authority to act for the client:

Si usted firma por el cliente, haga el favor de describir la autoridad con la que actúa por el cliente:

_____ _____

_____ _____

Note: If the person requesting the release of case information cannot sign his/her name, two witnesses to his/her mark X must sign below:

Nota. Si la persona que pide la divulgación de la información del caso no puede firmar su nombre, debe poner una marca (X) ante dos testigos, que deben firmar a continuación:

_____ _____
Witness / Testigo **Date** / Fecha

_____ _____
Witness / Testigo **Date** / Fecha

Notice to Client:

DHS or a provider agency, as receiver of this information, will protect your personal health information in accordance with federal and state privacy regulations. If you authorize release of your health information to other parties, it may no longer be protected by privacy regulations.

You can withdraw the permission you have given your doctors, medical facilities, or other health care providers to use or disclose health information that identifies you, unless they have already taken action based on your permission. You must withdraw your permission in writing.

Aviso al cliente:

El DHS o la agencia proveedora, como entidad que recibe esta información, protegerá su información médica personal de acuerdo con las regulaciones federales y estatales sobre la vida privada. Si usted autoriza la divulgación de su información médica a terceros, es posible que ya no esté protegida por las regulaciones sobre el derecho a la vida privada.

Usted puede retirar el permiso que les haya dado a su doctor, centros médicos o a otros proveedores de atención médica para usar o divulgar información médica que lo identifica a usted, a menos que éstos ya hayan actuado de acuerdo con su permiso. Tiene que retirar su permiso por escrito.