Authorization Validation Checklist

HIPAA required Components

	Name of health care provider authorized to disclose PHI.
	Name of patient in whom the PHI pertains to and verify if a UCLA patient. Must contain correct patient identifiers (Date of Birth, First/Last Name).
	Request and Verify patient's identification (Driver's license, Passport).
	Name of person(s) or class of persons to whom this information is to be sent. (for authorizing designating a copy service, the name of the copy service MUST be included on the authorization signed by the patient or personal representative) A stamp is not adequate.
	Description of the PHI .
	Description of the purpose of the disclosure.
	Expiration date or event which the authorization is no longer valid. Validate that authorization is not expired.
	Signature and date of one of the following:
	Patient.
	Parent or Guardian, if patient is a minor child and no legally protected information.
	Personal Representative (documentation describing relationship required).
	Authorization cannot be altered: erased, whited-out, stamped, typed over.
	Authorization is written in pen or typed. Authorization written in pencil is NOT acceptable.
	Authorization in written in plain language.
	Authorization must be in 14.0 font.
	If legally protected PHI information (Substance abuse, Psychiatric) is in the requested materials, it must be specifically authorized and included in the written authorization.
	If records are picked up by the patient or representative a signed acknowledgement of receipt of records must be signed.

Required Statements that must be included in the Authorization

	Statement that provider will not condition treatment, payment, or enrollment in health plan or eligibility for benefits on whether the individual gives authorization. Or an explanation of consequences of refusal to sign.
	Right to revoke authorization- including instructions of how to do so and exceptions to this right.
	Potential for re-disclosure of disclosed information if recipient is not subjected to privacy regulations or otherwise required to maintain confidentiality.
	Statement advising the individual of his/her right to receive a copy of the authorization.
	Statement of the patient's right to refuse to sign the authorization.

Date ____________ ROI by: Print Name ____________ Signature ____________

Patient Name	MRN #	Requestor	Date of Request

Requests for patient's PHI requires a valid HIPAA compliant authorization. Completed authorization will be retained on file for 6 years.