NOTICE OF INVALID AUTHORIZATION TO DISCLOSE INFORMATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
LEGAL ADVISORY UNIT
SFN 1478 (10-2013)

Clear Fields

Name of Agency		Date	
Address	City	State	ZIP Code

Section 164.508 of the HIPAA Privacy Rule prohibits a covered entity from disclosing protected health information without a valid authorization, except as otherwise permitted or required by the Privacy Rule.

The enclosed authorization form is being returned to you, as it is missing one or more of the core elements required by the Privacy Rule:

- ☐ Specific and meaningful description of the information to be disclosed.
- ☐ The name or other specific identification of the person(s) or class of persons authorized to disclose the information.
- ☐ The name or other specific identification of the person(s) or class of persons to whom we may make the disclosure.
- ☐ A description of each purpose of the requested disclosure.
- ☐ An expiration date or event that relates to the individual or the purpose of the disclosure.
- ☐ The signature of the individual and date signed. If signed by a personal representative of the individual, a description of the representative's authority to act for the individual.
- ☐ A statement of the individual's right to revoke the authorization in writing:
  a. A reference to the revocation right and procedures described in the notice of privacy practices, or
  b. A statement about the exceptions to the right to revoke and a description of how the individual may revoke the authorization.
- ☐ A statement about the ability or inability of the covered entity to condition treatment, payment, enrollment, or eligibility on signing the authorization by either:
  a. Stating the covered entity may not condition treatment, payment or eligibility on signing the authorization, except for research-related treatment or determining eligibility for a health plan, or
  b. Consequences of refusal to sign, if conditions permitted.
- ☐ A statement that information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.

Enclosed is a ND Department of Human Services **Authorization to Disclose Information** form (SFN 1059), which contains all of the core elements required by the Privacy Rule, which you may use for review or to request information, or both.

If you have any questions regarding this notice, please contact:

Name of Contact			Telephone Number
Title	Division/Unit		
Address	City	State	ZIP Code