

	Effective Date:	09-12-2011	
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PURPOSE

This is to provide a policy and procedure on how and when to obtain a HIPAA compliant authorization for the purpose of marketing.

DEFINITIONS

Refer to HIPAA Glossary

POLICY

All communications that market a product or service that encourage recipients of the communication to purchase or use the product or service requires a valid signed authorization by the recipient of the communication.

The authorization must inform the recipient if director or indirect remuneration has been exchanged for the use and disclosure of the PHI to make the marketing communication.

Not Marketing – No Authorization Required

- To describe a health related product or service (or payment for such product or service) that is provided by, or included in, a plan of benefits of the covered entity making the communication, including communications about: the entities participation in a health care provider network, or health plan network; replacement of, or enhancements to, a health plan; and health related products or services available only to a health plan enrollee that add value to but are not part of, a plan of benefits.
- To treat the individual,
- For case management or care coordination for the individual or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual.

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PROCEDURE

<i>Responsibility</i>	<i>Action</i>
Authorization Required	Obtain signed HIPAA compliant authorizations prior to communicating with any recipients regarding marketing material and information. If direct or indirect remuneration is exchanged for the PHI data, the recipient of the communication must be informed of the arrangement on the authorization form.
Not Marketing	<p>The following communications by Managed Care Organizations are not marketing and do not require a signed authorization.</p> <p>Providing information:</p> <ul style="list-style-type: none"> a. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities participation in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health related products or services available only to a health plan enrollee that add value to but are not part of, a plan of benefits. b. To treat the individual, c. For case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual.

REFERENCES

[45 CFR 164.501, §164.508\(a\), §164.508\(b\), §164.514\(f\)](#)