Hartford HealthCare
Connect to healthier.

104507

MR#:_____
Date Completed:_____
Pages Copied:_____
Initials:_____

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

Subject to the statements printed on the back, I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Patient Name: _____ **Date of Birth:** _____

FILL OUT BELOW TO DISCLOSE/OBTAIN

I authorize _____ to disclose/obtain health information to: _____
Facility Name

Address _____

Tele#: _____ Fax#: _____

Method of Disclosure/obtain:
❑ Mail ❑Verbal ❑Pick-up ❑Review ❑Electronic ❑ MyChart ❑ Fax _____

The dates of service and the type(s) of information to be used or disclosed are as follows:
□ Mental Health Record □ Substance Abuse Records □ HIV-Related Information
Date(s) of Treatment or Date Range: _____

❑ History & Physical	❑ Discharge Summary	❑ ED Record	❑ Operative Reports	❑ Consultations
❑ Laboratory Reports	❑ Radiology Reports	❑ Radiology Films	❑ Pathology Reports	❑ Progress Reports
❑ Billing Records	❑ Treatment Plan	❑ Psychiatric Evaluation	❑ Summary	❑ Entire Record
❑ Patient Portal Enroll		❑ Other _____		

The purpose of this disclosure or use is for the following reason: (Optional**)**
❑ Medical ❑ Legal ❑ Disability ❑ Insurance ❑ At the request of the patient ❑ Other _____

- This authorization will expire (date) _____. If date is not completed, this authorization will expire one year from the date of signature below. I understand that I may revoke this authorization at any time by notifying Patient Relations in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- I understand that my treatment or continued treatment is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information to be used or disclosed.

Authorization can be sent to:
☐ **Backus Health Information Management, 326 Washington Street, Norwich, CT 06360 - Fax# 860.892.2723**
☐ **HH Health Information Management, 80 Seymour St, Bliss 139, Hartford, CT 06102 – Fax# 860.545.6764 or 545.6446**
☐ **IOL Health Information Management, 80 Seymour St, Bliss 139, Hartford, CT 06102 – Fax# 860.545.2328**
☐ **HOCC Health Information Management, 100 Grand Street, New Britain, CT 06050 - Fax# 860.224.5920**
☐ **MidState Health Information Management, 435 Lewis Avenue, Meriden, CT 06451 - Fax# 203.694.7605**
☐ **Natchaug Health Information Management, 189 Storrs Road, Mansfield Center, CT 06250 - Fax #860.456.1381**
☐ **Rushford Health Information Management, 1250 Silver Street, Middletown, CT 06457 - Fax#860.346.9038**
☐ **Windham Health Information Management, 112 Mansfield Avenue, Willimantic, CT 06226 - Fax# 860.456.6885**
☐ **Charlotte Hungerford Health Information Management, 540 Litchfield Street, Torrington, CT 06790 – Fax# 860.496.6633**
☐ **Hartford Healthcare at Home, 181 Patricia M. Genova Dr., Curtiss Building, HIM Dept. 3rd FL, Newington, CT 06111**
☐ **Hartford Healthcare Medical Group**_____
☐ **Other:** _____

_____ _____ _____
Signature of Patient or Legal Representative **Date** **Time**

Relationship to patient: ❑ Self ❑ Parent ❑ Guardian ❑ Conservator ❑ Power of Attorney
❑ Administrator / Executor of Estate

If signed by the legal Representative, attach appropriate documentation to verify authority

Original copy to Medical Records **Photocopy to Patient**

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HIV RELATED INFORMATION

In the event that information release constitutes confidential HIV related information protected under Connecticut Law: this information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION

If the event that information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law Prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without The specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly Permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict Any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.