Hartford Hospital
A Hartford HealthCare Partner

ASSIGNMENT AND AUTHORIZATION

Rev. 03/12

6816

PATIENT'S NAME (LAST , FIRST , M.I.)	DATE OF BIRTH	HH ACCOUNT NUMBER	HH MEDICAL RECORD #	DATE OF SERVICE

GUARANTOR'S NAME & ADDRESS

PRIMARY

PAYOR PLAN				SUBSCRIBER'S RELATIONSHIP TO PATIENT
NAME AND ADDRESS OF INSURANCE COMPANY				
SUBSCRIBER'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX	POLICY NUMBER
SUBSCRIBER'S ADDRESS				
SUBSCRIBER'S EMPLOYER AND ADDRESS				

SECONDARY

PAYOR PLAN				SUBSCRIBER'S RELATIONSHIP TO PATIENT
NAME AND ADDRESS OF INSURANCE COMPANY				
SUBSCRIBER'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX	POLICY NUMBER
SUBSCRIBER'S ADDRESS				
SUBSCRIBER'S EMPLOYER AND ADDRESS				

THIRD

PAYOR PLAN				SUBSCRIBER'S RELATIONSHIP TO PATIENT
NAME AND ADDRESS OF INSURANCE COMPANY				
SUBSCRIBER'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX	POLICY NUMBER
SUBSCRIBER'S ADDRESS				
SUBSCRIBER'S EMPLOYER AND ADDRESS				

FOURTH

PAYOR PLAN				SUBSCRIBER'S RELATIONSHIP TO PATIENT
NAME AND ADDRESS OF INSURANCE COMPANY				
SUBSCRIBER'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX	POLICY NUMBER
SUBSCRIBER'S ADDRESS				
SUBSCRIBER'S EMPLOYER AND ADDRESS				

MEDICARE PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT GUARANTEE

I, patient, certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is accurate and complete. I authorize any holder of medical or other information about me to release such information to the Social Security Administration, its intermediaries or carriers, medical review boards and other organizations as necessary to administer the Medicare program. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

I hereby authorize payment directly to Hartford Hospital and/or Connecticut Children's Medical Center and/or Midstate Medical Center as applicable and /or any attending physician or physician group providing services under my account number otherwise payable to me, including the right under the Connecticut General Statutes to receive interest from the insurer on any claim not paid within 45 days (not to exceed hospital charges). Patient and guarantor hereby agree to pay Connecticut Children's Medical Center and/or Hartford Hospital and/or Midstate Medical Center and/or any attending physician or physician's group in full for services rendered, or to be rendered to the above named patient, including any charges not paid for by the Medicare program, any charges not covered by any assignments made hereunder, any late charges which may be imposed, and all costs of collecting amounts due, including attorneys' fees. Payment is due in full within one month of the date of each bill.

NOTICE

Pursuant to Public Act 02-92, all self-pay patients may, upon request, receive a copy of hospital charges related to services provided to them.

If you would like to obtain a copy of your hospital charges, please contact the party below.

PATIENT ACCOUNT REPRESENTATIVE at the toll free telephone number: 1-888-515-5544

AUTHORIZED REPRESENTATIVE	DATE	WITNESS

TAKEN FROM RECORDS ON: _____ **20** _____

SIGNED BY:

MEDICAL RECORDS

CONSENT FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

PLEASE READ THIS FORM AND ASK ANY QUESTIONS BEFORE SIGNING

Hartford Hospital ("the Hospital") is a member of the Hartford HealthCare ("HHC") system of hospitals and other health care providers which share a system-wide electronic medical record. Therefore,all of your clinical information goes into the HHC medical information data base called HHC MyHealthConnect. For the appropriate coordination of your care, it is important that your medical information be shared with other providers involved in your care within HHC and the providers who are involved in your care. Your medical information will only be shared or accessed with your permission under this consent.

I, the undersigned patient, consent to have the Hospital to obtain, use and disclose my protected health information whether such information is in electronic or paper format or stored or managed in HHC MyHealthConnect, including, if applicable, prescription information, drug/alcohol abuse, HIV and psychiatric information for the purposes of my treatment or coordination between health care providers, discharge planning, research which doesn't use my identity, healthcare operations and payment by third-party payor(s) listed in the payor section on the back of this form.

In addition, I authorize the Hospital to disclose my protected health information to the following for the following:

☐ Other: _____

I have been provided with the Hospital's Notice of Privacy Practices ("Notice") and understand that I have the right to review this notice before signing this consent. I have also been provided with a copy of the Frequently Asked Questions (FAQs) concerning HHC MyHealthConnect. I understand that the Hospital reserves the right to change its privacy practices, described in its Notice and FAQs, and that if I wish to receive notification of any changes to these, I may contact **Patient Relations at 860-545-1400** or go to the hospital's web site at www.harthosp.org.

I understand that I have the right to refuse signing this consent. If I refuse to sign this consent, the Hospital may provide me with treatment however; I will be responsible for charges incurred. I understand that treatment required by law, such as emergency care will be provided to me whether or not I sign this consent.

Unless I object, I understand that the Hospital may disclose general information about me (name, location in facility, general condition and religious affiliation) from the facility directory to clergy and persons asking for me by name. Unless I object, the Hospital may also disclose protected health information of a general nature to my family or other individuals personally involved in my care, including changes in my condition.

I have the right to request that the Hospital restrict how they use and/or disclose my protected health information for the purpose of providing treatment, obtaining payment and/or conducting health care operations. The Hospital is not required to agree to any restriction I request. If the Hospital does decide to agree to my request, the Hospital must honor the restriction placed on the use and/or disclosure of my health information. I also understand that I have the right to request confidential communications by alternate means or locations. However, the hospital may deny the request if it determines that is would be administratively difficult to comply with my request.

I understand that with respect to drug/alcohol abuse, HIV and psychiatric information, this Consent will expire 365 days after the date appearing below or 365 days after my final treatment, whichever is later. I also understand that I have the right to revoke this consent by notifying **Patient Relations** in writing. I understand that if I revoke my consent, there will be no effect on uses and disclosures already made in reliance on my prior consent.

I have had the opportunity to have all my questions answered regarding the Hospital's privacy practices. I have received a copy of the Notice of Privacy Practice and the Frequently Asked Questions concerning HHC MyHealthConnect and consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations.

☐ **I do not want my personal health information to be shared in HHC My HealthConnect.**

_____ _____ _____

Signature of Patient or Legal Representative/Witness **Date** **Time**

If signed by the Legal Representative, indicate your relationship to the patient below:

☐ Parent ☐ Guardian ☐ Conservator ☐ Executor of Estate ☐ Power of Attorney ☐ Other _____

If unable to obtain patient's consent, indicate the reason below:

☐ Emergency treatment situation

☐ Required by law to treat the patient and the Hospital has attempted but is unable to obtain the patient's consent.

☐ Substantial barriers to communicating with the patient (ie. Foreign language) and the Hospital determines that the patient's consent to receive treatment is inferred from the circumstances.

☐ Patient refuses to sign to consent

_____ _____ _____

Signature of Witness (Person documenting reason) **Date** **Time**

NOTICE

HIV RELATED INFORMATION

In the event that information released 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

In 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 Federeal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.