Hartford Hospital
A Hartford HealthCare Partner

Phone: 860-545-4764
Fax: 860-545-6764

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 FOR HARTFORD HOSPITAL TO DISCLOSE	FILL OUT FOR HARTFORD HOSPITAL TO OBTAIN
I authorize the **Hartford Hospital** to disclose health information to: Name: _____ Facility: _____ Address: _____ _____ Tele#: _____ Fax#: _____	I authorize _____ To disclose health information to Dept:_____ Hartford Hospital 80 Seymour Street P.O. Box 5037 Hartford, CT 06102-5037 Contact Person:_____ Tele#:_____ Fax: _____
Method of Disclosure: ❑ Mail ❑ Verbal ❑ Pick-up ❑ Review	

The dates of service and the type(s) of information to be used or disclosed are as follows:

Date(s) of Treatment: _____

❑ History & Physical	❑ Discharge Summary	❑ ED Record	❑ Operative Reports	❑ Consultations
❑ Laboratory Reports	❑ Radiology Reports	❑ Radiology Films	❑ Pathology Reports	❑ Progress Reports
❑ Billing Records	❑ Entire Record	❑ Other _____		

The purpose of this disclosure or use is for the following reason:

❑ Medical ❑ Legal ❑ Disability ❑ Insurance ❑ At the request of the patient ❑ Other _____

- This authorization will be valid for a period of one year from the date 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 by Hartford Hospital 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. I understand there is a charge for copies.
- The parent of legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian.
- Minors receiving drug abuse treatment or treatment of venereal disease may sign their own authorization.

Authorization can be sent to: **Health Information Management**
80 Seymour Street Bliss 139
Hartford, CT 06102-5037

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

_____
Witness

Relationship to patient: ❑ **Self** ❑ **Parent** ❑ **Guardian**

❑ **Conservator** ❑ **Executor of Estate** ❑ **Power of Attorney** ❑ **Other** _____

If signed y the legal Representative attach appropriate documentation to verify authority

White Copy – Medical Record Yellow Copy - Patient

Hartford Hospital
A Hartford HealthCare Partner

Phone: 860-545-4764
Fax: 860-545-6764

104507

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

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.