BRISTOL HOSPITAL
everyday extraordinary

P.O. Box 977
Bristol, CT 06011-0977
860-585-3000

CONSENT TO DISCLOSE AND/OR OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Telephone: _____

Covering the periods of health care:

From (date): _____ To (date): _____

Information to be disclosed:

- ☐ Abstract (Discharge Summary, History & Physical, Consults, Emergency Record, Operation, and all testing)
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Emergency Room record
- ☐ Operative Report
- ☐ Pathology ☐ Slides
- ☐ Laboratory tests
- ☐ Radiology ☐ CD ☐ Reports
- ☐ Therapy (physical, occupational, speech, cancer care)
- ☐ Psych/Drug/Alcohol/HIV (Inpatient/Outpatient)
- ☐ Verbal Discussion
- ☐ Other _____

_____ _____

Patient Signature/Legal Representative and relationship to patient Date / Time

FILL OUT FOR BRISTOL HOSPITAL TO DISCLOSE	FILL OUT FOR BRISTOL HOSPITAL TO OBTAIN
I authorize the Bristol Hospital to disclose health information to. Name: _____ Facility: _____ Address: _____ _____ Tele#: _____ Fax#: _____ Email: _____	I authorize _____ To disclose health information to Dept: _____ Bristol Hospital _____ _____ Bristol, CT 06010 Contact Person: _____ Tele#: _____ Fax#: _____ Email: _____
Method of Disclosure: ☐ Mail ☐ Verbal ☐ Pick-up ☐ Review ☐ Email ☐ Fax	

See page 2 for disclosure statements.

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CONSENT TO DISCLOSE AND/OR OBTAIN PROTECTED HEALTH INFORMATION

This information is being disclosed for the purpose of *(legal, continued care, insurance, workman's compensation, personal use, disability):* _____

Authorization Statements:

This authorization may be revoked in writing at any time, except to the extent that actions have already been taken in reliance on this authorization. This authorization will expire in one year or end of treatment .

A copy of the of the information to be disclosed may be requested including a copy of the signed authorization form. There may be a $.36 per page or $5.00 for CD / DVD copying fee.

Bristol Hospital and staff are hereby released from any legal responsibility or liability for the authorized disclosure of the protected health information outlined in this authorization. By signing this authorization the authorized recipient of the protected health information provided by Bristol Hospital understands that the ownership and confidentiality is their sole responsibility.

Disclosure Statement:

This authorization is voluntary and the information released may include information relating to AIDS, HIV infection, behavioral health services, psychiatric care, alcohol and drug abuse (a separate authorization is required for the release of psychotherapy notes) If the organization authorized to receive this information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Re-disclosure Statement:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2) prohibit 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 such regulations. A general authorization for the release of medical information is not sufficient for the re-release of information containing HIV, behavioral health alcohol or drug abuse.

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