Bristol Health

CONSENT TO DISCLOSE AND/OR OBTAIN PROTECTED HEALTH INFORMATION

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

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 HEALTH TO DISCLOSE	FILL OUT FOR BRISTOL HEALTH TO OBTAIN
I authorize the Bristol Health to disclose health information to: Name: _____ Facility: _____ Address: _____ _____ Tele #: _____ Fax #: _____ Email: _____	I authorize _____ To disclose health information to Dept: _____ Bristol Health _____ _____ Bristol, CT 06010 Contact Person: _____ Tele #: _____ Fax #: _____ Email: _____
Method of Disclosure: ☐ Mail ☐ Email ☐ Fax	

See page 2 for disclosure statements.

CONROI

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

Authorization/Disclosure Statements:

This authorization is voluntary and I may refuse to sign it. The above named provider may not condition treatment on refusal to sign this authorization. It may be revoked in writing at any time to the Health Information Management Department except to the extent that actions have already been taken on it. Unless revoked, this authorization will expire on the following date, event or condition _____. If I fail to specify a date, this authorization will expire in one year.

I understand that I may inspect or request a copy the information to be disclosed along with a copy of this authorization as provided in CFR 164.524. There may be a $.36 per page fee or $5.00 for CD/DVD copying fee.

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

I understand the protected health information released may include information relating to AIDS, HIV infection, behavioral health services, psychiatric care, or substance use disorder. (A separate authorization is required for the release of psychotherapy notes.)

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, or substance use disorder.

Any information disclosed per the authorization may be re-disclosed by the recipient and is no longer protected by federal privacy regulations.

CONROI