Day Kimball Healthcare 320 Pomfret Street Putnam, Connecticut 06260 860-928-6541
www.daykimball.org Email: MyHealthhelp@daykimball.org Fax: 860-963-6375

AUTHORIZATION FOR RELEASE OF INFORMATION
FROM DAY KIMBALL HEALTHCARE

PATIENT NAME:_____ **DATE OF BIRTH:**_____

I, hereby authorize **DAY KIMBALL HEALTHCARE** to disclose my protected health information to (list below):

NAME: _____ **PHONE #:** _____

ADDRESS: _____

EMAIL: _____**FAX #**_____

I understand that my health record may include general information related to the diagnosis/treatment of mental illness, drug/alcohol abuse or other information I may consider sensitive.

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

Date(s) of Treatment: _____

GENERAL RECORDS

- ☐ Discharge Summary ☐ History & Physical ☐ Operative Reports
- ☐ Consultations ☐ Progress Notes ☐ Emergency Room Record
- ☐ Nurses Notes ☐ Laboratory Results ☐ Radiology Reports
- ☐ Pathology Reports ☐ PT/OT/ST Notes ☐ Billing Records
- ☐ Other (please specify): _____

PROTECTED RECORDS
If psychiatric records, substance abuse records, HIV-related information or reproductive health records is to be used or disclosed, please indicate specific consent for such disclosure below.

- ☐ Psychiatric Records, including psychotherapy notes
- ☐ HIV Records ☐ Substance Abuse Records ☐ Reproductive Health Records

PURPOSE OF RELEASE OF THIS INFORMATION

- ☐ Medical Care ☐ Attorney/Legal Case ☐ Personal Use ☐ Other: _____
- ☐ Disability ☐ Insurance ☐ Workers Comp

I UNDERSTAND THAT:

- I may revoke this authorization at any time by providing written notice to Day Kimball Healthcare. I understand that I may not be able to revoke this authorization to the extent that Day Kimball Healthcare has taken action in reliance on the authorization.
- This authorization is voluntary. Day Kimball Healthcare will not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. I am signing this authorization freely, and no one has coerced or pressured me to sign this authorization.
- The protected health information (PHI) under this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations.
- If the PHI that is disclosed under this authorization is confidential HIV/AIDS related information, psychiatric or other protected mental health information, or alcohol or drug abuse related information or reproductive health information, the recipient may be prohibited from redisclosing that information under federal or Connecticut state law.

EXPIRATION OF AUTHORIZATION:
This Authorization will expire on: _____
(Enter a specific date up to one year from today)

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

_____ _____ _____ _____
Signature of Patient/Parent/Legal Representative* **Date** **Time** **Relationship to Patient**

*If signing as a legal representative, please provide paperwork to support representative status.

Day Kimball Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, are deaf or hard of hearing, language assistance services are provided free of charge. Call (860) 928-6541 ext. 2342 or ext. 2229; for TTY, dial 711 and ask to be connected to (860) 928-6541 ext. 2342 or 2229.