

# Day Kimball Hospital

320 Pomfret Street Putnam, Connecticut 06260

860-928-6541/774-3366

www.daykimball.org

## AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

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

NAME: \_\_\_\_\_

PHONE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Reports     |
| <input type="checkbox"/> Consultations                 | <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Emergency Room Record |
| <input type="checkbox"/> Nurses Notes                  | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Radiology Reports     |
| <input type="checkbox"/> Pathology Reports             | <input type="checkbox"/> PT/OT/ST Notes     | <input type="checkbox"/> Billing Records       |
| <input type="checkbox"/> Other (please specify): _____ |   |  |

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

#### PROTECTED RECORDS

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Psychiatric Records | <input type="checkbox"/> HIV Records | <input type="checkbox"/> Substance Abuse Records |
|--|--------------------------------------|--|

#### PURPOSE OF RELEASE OF THIS INFORMATION

- |                                       |  |                                       |                                       |
|---------------------------------------|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Attorney/Legal Case | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Disability   | <input type="checkbox"/> Insurance           | <input type="checkbox"/> Workers Comp |                                       |

#### I UNDERSTAND THAT:

- I may revoke this authorization at any time by providing written notice to Day Kimball Hospital. I understand that I may not be able to revoke this authorization to the extent that Day Kimball Hospital has taken action in reliance on the authorization.
- This authorization is voluntary. Day Kimball Hospital 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.
- 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, 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

\_\_\_\_\_  
Relationship to Patient

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