THE WILLIAM W. BACKUS HOSPITAL

326 Washington Street Norwich CT 06360

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ______________________ Social Security #______________

Date of Birth __________ Date of Admission or specific Treatment Date(s)______________

AKA (Other names) ______________________

I hereby authorize The William W. Backus Hospital to disclose my individually identifiable health information to ______________________

(Name & address of individual, organization or agency and address)

in the manner described below.

I hereby authorize ______________________

(Name and address of individual, organization or agency and address)

to disclose identifiable information in the manner described below to The William W. Backus Hospital.

1. Information should be delivered via (select one)		Mail (provide address):		
		Fax (provide fax number):		
		Pick-up (provide name of individual picking up information):		
2. Purpose of this disclosure (check all that apply)		Continuation of medical care		Attorney
		Substantiation of payment claims		Personal use
		Other (specify):		
3. Information to be disclosed (include dates where appropriate)		Emergency Records		Consultations
		History & Physical		Physicians' orders
		Progress Notes		EKGs
		Operative Note		Physical Therapy Record
		Laboratory/Pathology Reports		Diagnostic Imaging Exams
		Discharge Summary		Entire Record
		Other (specify):		
4. If you are the legally authorized representative of the patient, describe the scope of your authority to act on the patient's behalf		Parent		
		Durable Power of Attorney for Health Care (attach proof of authority)		
		Legally Authorized Representative (attach proof of authority)		
		Personal Representative of the Estate (attach proof of authority)		
		Other (specify and attach proof of authority)		

5. I understand that my signature below specifically authorizes the disclosure of information related to Alcohol/Drug abuse testing and treatment, HIV and AIDS testing, diagnosis, or treatment, and/or Mental Health Record. See "Special Notices" on page two.

6. **I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.**

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

8. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information.

9. I understand that this authorization will expire in __________ days.

Signature of Patient or Legally Authorized Representative ______________________ Date ______________

Relationship to Patient ______________________ Witness ______________________

ID Checked by ______________________