MidState Medical Group
A Hartford HealthCare Partner

Patient Authorization to Use or Disclose Protected Health Information

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Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my protected health information as described below.
I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider-the released information may no longer be protected by federal privacy regulations.

Patient name: ______________________________ **Date of Birth:** ______________

Person/organization providing the information: ______________________________
____
____

Person/organization receiving the information: ______________________________
____
____

Description of the information to be used or disclosed, including date(s) *(check all that apply)*:

[ ] The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed).

[ ] The patient's demographic information *(check all that apply)*:
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age [ ] Gender [ ] Race [ ] Other: ______________

[ ] Medical Data/Information as related to:
[ ] Specific condition(s): ______________________________
[ ] Specific professional service(s): ______________________________
[ ] Specific medication(s): ______________________________
[ ] Other: ______________________________

[ ] Other: ______________________________

Specific purpose(s) of the information (including date(s)):

____

Section B: Must be completed only if specific information listed below is requested

The type of information listed below ***CANNOT BE USED OR DISCLOSED WITHOUT MY SPECIFIC CONSENT AND KNOWLEDGE.*** *Therefore, I have* ***INITIALED*** *(any other mark not acceptable) before each type of record that I authorize you to use or disclose.*

________ Alcohol and/or Drug Abuse Treatment records Initial
________ Mental Health Treatment records Initial
________ AIDS, ARC or HIV Testing records Initial

Section C: Must be completed only if a health plan or health care provider requested authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure? ____

   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?
      Yes _____ No_____

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: _______

   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
      Initials: _______

Section D: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on __ __/ __ __/ __ __ __ __ (DD/MM/YR) Initials:________
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.
   Initials: _______

____ ____________________
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)
Printed name of patient's representative:
____
Relationship to the patient:
____

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****

FOR OFFICE USE ONLY
Authorization added to the patient's medical record on ____

Authorization verified by ____________________________________ on ______________________________

REDISCLOSURE IS PROHIBITED
This information has been disclosed to you from records protected by Federal law, 42-CFR Part II and State law concerning confidentiality. The Federal rules and State law prohibit you from making any further disclosure of this information unless further disclosure is expressively permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42-CFR Part II and State law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.