GENERAL AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

GRIFFIN HOSPITAL
130 DIVISION STREET DERBY, CT 06418
Telephone: (203) 732-7390 Fax: (203) 732-1390

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

[ ] I hereby authorize Griffin Hospital to review/release information to:
(LIST PERSON OR ORGANIZATION, ADDRESS, CITY, STATE, & ZIP CODE)

_____

_____

_____

[ ] I hereby authorize Griffin Hospital to obtain information from:

_____

_____

_____

Patient Name:_____ **Date of Birth:**_____

Patient Address:_____ **Patient Telephone:**_____

Dates of Treatment to be Released:_____

Specific information to be released: (Check and Initial each that you are authorizing to be released)

Discharge Summary	☐_____	**Laboratory Reports**	☐_____	**Emergency Dept Record**	☐_____
Operative Report	☐_____	**Xray Reports**	☐_____	**Physical Therapy Notes**	☐_____
Consultation Reports	☐_____	**Pathology Reports**	☐_____	**Other:**_____	☐_____

Purpose of disclosure/use of protected health information:_____
(Not required if information is being released to patient)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE

I understand that if a person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations.

(If applicable) I understand that the person I am authorizing to use/disclose information may receive compensation for doing so.

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 obtain a copy of any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken by Griffin Hospital in reliance on this authorization. Requested Revocation Date:_____ **Intl:**_____
If not previously revoked, this consent will terminate within 90 days from the date of signature.

FOR ON-SITE REVIEW PURPOSES ONLY: Appointment Date: Time:
Reviewed by:_____ **from:**_____ **Witness:**_____

DATE:	PATIENT/AUTHORIZED PERSON'S SIGNATURE:
WITNESS:	

If the patient has not signed this form, please specify the signer's relationship to the patient, and explain why the patient did not sign.

_____

Clerical signature: _____ **Date:** _____ **#pages:** _____

Identification Verified _____ **Intl.. (Attach copy of photo I.D. or identifying document)**