Authorization to Use or Disclose Health Information
For Hartford Medical Group

Patient Name: _____ Health Record Number: _____
Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)
   - ☐ Entire record
   - ☐ Immunization records
   - ☐ Physical exam results
   - ☐ Problem list
   - ☐ Medication list
   - ☐ List of allergies
   - ☐ Most recent history
   - ☐ Most recent discharge summary
   - ☐ Lab results (please describe the dates or types of lab tests you would like disclosed): _____
   - ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): _____
     Consultation reports from (please supply doctors' names): _____
     Other (please describe): _____
3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. The information identified above may be used by or disclosed to the following:
   - ☐ Individuals
   - ☐ Organization(s)
   - ☐ Education system/school
   - ☐ Sports /summer camps
   - ☐ Life Insurance Company
   - ☐ Attorney
   - ☐ Name: _____
     Address: _____
   (a) Name: _____
     Address: _____
5. This information for which I'm authorizing disclosure will be used for the following purpose:
   - ☐ My personal records
   - ☐ Sharing with other health care providers as needed
   - ☐ Third party requirement _____
   - ☐ Other (please describe): _____
6. 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 health information management department. 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 when the law provides my insurer with the right to contest a claim under my policy.
7. Unless I specify differently, this authorization will expire on (insert date or event): _____. If I fail to specify an expiration date/ event, this authorization will expire six months from the signature date.
8. I understand that once the above information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by federal privacy laws or regulations.
9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative _____
Date (and if signed by legal representative, relationship to patient) _____ (_____)
Signature of HMG witness _____
Date distribution of copies: Original to provider; copy to patient; copy to accompany use or disclosure

Hartford Medical Group – Privacy Officers
Bishops Corner, West Hartford - Bette Long, Practice Mgr., 232-4891
Windsor - Charlene Baden, RN, Practice Mgr., 683-2690
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East Hartford - Allen Holloway, Practice Mgr., 569-8800
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