Bermuda Hospitals Board
Health Information Management Services

King Edward Memorial Hospital
7 Point Finger Road, Paget, DV 04 | Tel: (441) 239-1483 | Fax: (441) 236-0414

Mid-Atlantic Wellness Institute
44 Devon Spring Road, Devonshire FL 01 | Tel: (441) 239-3265 | Fax: (441) 239-2271

Authorization for Uses and Disclosures of Health Information

1	**Last Name:**	**First Name:**		**Middle Initial:**
	Patient Former Name:			**MRN:**
	DOB ***(DD/MMM/YYYY):***	**Age:**	**Gender: M/F**	**Nationality/Status:**
	Address: _____ _____			
	Contact Information:			
	H:	**W:**	**C:**	**Email:**
2	**I authorize BHB HIMS Department to release or disclose: (please ☑ one)** ☐ My entire medical record ☐ Only those portions pertaining to *(be specific, include provider name and date(s) of treatment, if applicable)*: _____			
3	**Disclosed records to** ***(Name/Facility):*** _____ **Address:** _____ _____			
4	**Reason for disclosure:** ☐ Further medical care ☐ Payment of Insurance claim ☐ Legal Investigation ☐ Applying for Insurance ☐ Vocational rehab, evaluation ☐ Disability determination ☐ At the request of the individual ☐ Other – specify: _____			
5	This authorization is valid for disclosures to the recipient above for a period of six months, and it automatically expires in six months from _____to_____ *(same date as date signed).* ***(DD/MMM/YYYY)*** ***(DD/MMM/YYYY)***			
6	I understand that I am responsible to notify the HIMS Dept. of visit(s) that I wish to have disclosed to this recipient. I understand that I may revoke this authorization by providing a written statement to the BHB HIMS Department, except to the extent that BHB HIMS Department has already completed the action on it. I understand that protected health information released pursuant to this authorization may be re-disclosed by the recipient(s) on this form to other individuals or organizations that are not subject to privacy protection laws. I understand that if I have received care from another facility on behalf of BHB, if the records of that treatment are part of my medical record, BHB HIMS Department will include it as part of the release. I also hereby release the BHB HIMS Department from all legal responsibilities and liabilities that may arise from the release of the information. There is a cost of .50 cents for each required document page. Service users wishing to review their Mental Health record will seek the permission of the Attending physician, in conjunction with the appropriate department. The physician, in collaboration with the appropriate department, Chief/Consultant Psychiatrist, will determine if access is to be given to all or part of the record. If access is granted, the record will be reviewed in the presence of Medical or Nursing personnel. Only information in the current admission will be reviewed. Denial may be appealed to the Chief of Staff or the Chief of Psychiatry as appropriate.			
7	_____ _____ ***Signature of Patient/Service User/Personal Representative*** ***Date (DD/MMM/YYYY)*** If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so: **Patient is:** ☐ minor ☐ incompetent ☐ deceased | **Legal Authority:** ☐ legal guardian ☐ next of kin of deceased			
8	_____ _____ ***Signature of Witness*** ***Date (DD/MMM/YYYY)***			

BHB HIMS Department Use Only

Date Received ***(DD/MMM/YYYY):***	**Date Released** ***(DD/MMM/YYYY):***	**ID Provided:** ☐Yes ☐No
Sent by: ☐ Mail ☐ Email ☐ Fax ☐ Collected	**Processed By:**	