Bermuda Hospitals Board

Health Information Management Services (HIMS)

King Edward Memorial Hospital
7 Point Finger Road, Paget, DV 04 | Tel: (441) 239-1483 | Fax: (441) 239-1711

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

Authorization for 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 only)

☐ My entire medical record ☐ Only those portions pertaining to *(be specific, include provider name and date(s) of treatment, if applicable)*: ____

3 **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 patient
☐ Other – specify: ____
Details (*be specific as to reason for request, as this will assist in preparing the response*):____
____

4 **The above information will be released to:**

Name: ____
Agency/Facility (if applicable):____
Address: ____
Contact Information: Telephone: ____________________________ **Email:**____

5 I understand that I may revoke this authorization by writing to the BHB HIMS Department at HIMS_Dept@bhb.bm the address above, following which no further disclosures will be made.

I understand that protected health information released pursuant to this authorization may be further disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I understand that if I have received care from another facility, 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, to the fullest extent permitted by law. There is a cost for each required document page of $1 for the first 20 pages, $0.75 per page 21-100 and $0.50 per page 100+ in addition to an administration fee of $10, payable on receipt of email invoice, either at the Cashier's office (9:15am-3:15pm daily) or after hours at the Registration Specialist counter in Admitting.

A request may be refused if the attending physician determines that release of a requested record would be likely to prejudice the patient's physical or mental health. Patients wishing to request the release of their Mental Health record should use the MWI Authorization to Release/Obtain Information form, which can be obtained from the BHB HIMS Department.

6

____ ____________________
Print Name of Patient/Parent or Guardian/Authorized Representative ***Date (DD/MMM/YYYY)***

____
Signature of Patient/Parent or Guardian/Authorized Representative

If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so:

Patient is: ☐ minor ☐ incapacitated ☐ deceased

Legal Authority: ☐ parent ☐ legal guardian ☐ administrator/executor of deceased ☐ other, please specify: ____________________

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________________________ ________________________ ____________________
Witness (Print name) ***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
Sent by: ☐ Mail ☐ Email ☐ Fax ☐ Collected	**Processed By:**	