Bermuda Hospitals Board

Health Information Management Services (HIMS)

King Edward VII 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) 239-3332 | Fax: (441) 239-2271

MWI Authorization to Release/Obtain Information

1

Last Name:	**First Name:**		**Middle Initial:**
Service User Former Name:			**MRN:**
DOB ***(DD/MMM/YYYY):***	**Age:**	**Gender: M/F**	**Nationality/Status:**

Address:

_____

_____

Contact Information:

H:	**W:**	**C:**	**Email:**

2

I authorize BHB to : (please ☑ one only)

☐ Release information ☐ Obtain information ☐ Release and obtain information

For Minor Children

I _____ **of** _____ **hereby authorize**
Parent or Guardian (delete as applicable) *Service User Name*

_____ **of Child and Adolescent Services, to seek/release confidential information**
Name of Person, Title or Position

about the following:

☐ Previous treatment and diagnosis ☐ School performance and behaviour ☐ Personal history ☐ Medical history ☐ Family history
☐ All of the above

3

The purpose of this information is:

☐ Further medical care ☐ Payment of Insurance claim ☐ Legal Investigation ☐ Applying for Insurance
☐ Vocational rehab, evaluation ☐ Disability determination ☐ At the request of the service user
☐ 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: _____

Address: _____

Contact Information:

T:	**Email:**

5

I understand that I may revoke this authorization by writing to the BHB HIMS Department at HIMS_MWI@bhb.bm or 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.

[Records will be released subject to 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.]

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 service user, state the relationship and/or reason and legal authority to do so:

Service User is: ☐ minor ☐ incapacitated ☐ deceased

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

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7	_____	_____	_____
	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:**	