



IMPORTANT FINE PRINT ABOUT RELEASING PATIENT MEDICAL RECORDS

The BHB Health Information Management Services Department recognizes the patient's right to confidentiality of medical records as set forth by Bermuda Law. You should be aware of these guidelines when requesting medical records.

The patient may request multiple releases of the information stated on the authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's, parent's or legal guardian's signature. A new authorization is necessary for release of information on care provided after the date of the patient's signature, unless you state in the authorization to release future records of "a specific test, specific clinic appointment, etc."

If the patient is 18 years or older, the patient must sign the release unless:

- 1) the patient is incompetent,
- 2) the patient is disabled and cannot sign the form, or
- 3) the patient is deceased. (The surviving spouse with legal proof or legal representative must sign to authorize release of records of the deceased patient.)

If the patient is 17 year or younger, the parent or legal guardian *must* sign release.

Anyone signing for release of records, other than the patient, must state their relationship to the patient and have available proof of legal authority to release the records.

Note to recipient of information:

This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.

A request for records concerning visits, procedures, or surgery done at a facility other than ours may have to be requested from that facility.



Bermuda Hospitals Board

CARING FOR OUR COMMUNITY

AUTHORIZATION FOR USES AND DISCLOSURES OF HEALTH INFORMATION BERMUDA HOSPITALS BOARD

Health Information Management Services Dept
7 Point Finger Road, Paget DV 04
P.O. Box HM 1023, Hamilton HM DX

Tel: (441) 236-2345 Ext.1483
Fax: (441) 239-6324

1 Patient last name: _____ First name: _____ Middle Initial: _____
Patient former name: _____ D.O.B.: _____ MRN: _____
Patient Address: _____ Patient email: _____
Patient home phone #: _____ Work phone #: _____ Cell phone #: _____

2 I authorize BHB Clinical Records Services Department to release or disclose (Information to be released, check 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: _____
_____ Attention: _____

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 BHB cannot release certain information unless you give us special permission to release it.
 Abortion AIDS/ARC Alcoholism Developmental disabilities
 Domestic/Sexual abuse Genetic Testing HIV Testing and related information Mental Health
 Privileged information Substance abuse Sexually Transmitted Diseases (STD)
 Other - specify: _____

6 This authorization is valid for disclosures to the recipient above for a period of six months, and it automatically expires in six months
From _____ (same date as date signed.) 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
Dept, except to the extent that BHB HIMS Department has already completed the action on it.

7 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.

8 Signature of patient/personal representative _____ Date _____

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

Patient is: minor incompetent disabled deceased
Legal authority: legal guardian next of kin of deceased

9 Signature of witness _____ Date _____

For BHB Clinical Records Services use:

Date received _____ I.D. provided _____ Date released _____
Processed by _____ Sent by mail _____ Picked up in person _____ Sent by Fax.....