Authorization For Release Of Information

Please complete all sections. Missing information may cause delays or the inability to retrieve your records.
Release may take up to 30 days to process.

Health Information Management Dept.
600 St. Johnsbury Road
Littleton, NH 03561
Phone: 603-444-9538 Fax: 603-259-7559

Please Print Patient Information *must be fully completed*

Name: _____ Previous Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Who has the information you want released.

Please list the specific hospital, physician office and/or home health agency

Provider / Facility: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Who do you want to receive your information?

I hereby authorize the above named facility/provider to:

☐ Release medical records,
☐ Speak to/discuss with,
☐ Both release medical records to and discuss medical information with

Provider / Facility / Person: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Email: _____

Information to be released:

What do you want shared? Check **appropriate** boxes.

Date(s) of service **From**: _____ **To**: _____

We do not accept "ALL" for dates of service. If left blank the last 2 years will be sent.

Check off the information you would like to be sent:

___ Abstract (summary of visits and all tests)
___ Emergency Room Visit(s) (Reports, tests, consults, etc.)
___ Physician Office Visit(s)
___ Radiology Reports
___ Laboratory Report
___ Operative Report
___ Immunizations
___ Inpatient Stay(s)
___ Nursing Notes
___ Radiology Images

Radiology Images will be available through Nucleus Online Portal.

___ Urgent Care
___ Cardiology Reports and Stress Tests
___ Pathology
___ Rehab PT/OT/ST
___ Billing Records
Other _____

Sensitive Information (***INITIAL*** to be released)

___ Drug & Alcohol testing and/or treatment records
___ Psychiatric Evaluation
___ Intake Assessment
___ Treatment Plan
___ Evaluations
___ HIV/AIDS/STD testing and/or treatment records
___ Mental Health Progress Notes

Purpose of Release (Why it is needed)

☐ Continuing Care ☐ Transfer of Care ☐ Personal Use/Review ☐ Insurance
☐ Attorney ☐ Workers Compensation ☐ Temporary Transfer of Care (school winter /away) ☐ Other (specify): _____

Fees may be charged in accordance with State and Federal Statutes

FOR LEGAL USE ONLY

Discussion/Testimony/Affidavits: I authorize the following individuals to discuss with me and/or _____
And to give sworn affidavits as to whatever s/he knows about my illness, injuries and treatment, as referenced on this form. _____ Any and all practitioners _____ Other staff _____ Other: _____

I understand that:

- I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences.
- I can revoke all or part of this authorization at any time during this time period by providing written notice to the Health Information Management Department, except where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits of other insurance coverage or benefits.
- I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information.
- I understand I am entitled to a copy of this authorization, upon request
- If any of the information disclosed pursuant to this request is from records protected by Federal confidentiality rules at 42 CFR Part 2, those rules prohibit the recipient from making any further disclosure of this information unless I expressly permit it through my written consent or redisclosure is performed as otherwise permitted in 42 CFR Part 1.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition. _____
I understand if I fail to specify an expiration date, event or condition, this authorization will expire 6 months from date signed. I also understand it is my responsibility if I document a long expiration date to cancel in writing to Littleton Regional Healthcare I wish to change.

Signature of Patient or Authorized Representative _____

Printed Name _____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney) _____

Date _____ Time _____

For Office Use Only

Medical Record #_____ **eCW#** _____ **Alpine#** _____
Visit ID _____ **Number of Pages** _____ **Number of Pages**_____
Number of Pages _____

Completed by _____
Records to be ( ) Faxed ( ) Mailed ( ) Picked Up ( ) Handed ( ) E-mail

Radiology images to be ( ) Shared with Nucleus ( ) Export to CD

Date completed _____

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600 St. Johnsbury Rd
Littleton, NH 03561