

**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.

**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.**

Provider: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**Who do you want to receive your information**

I hereby authorize the above-named hospital/physician office to:  
 Release medical records, to  Speak to/discuss with,  Both release medical records to and discuss medical information with,  
Name: \_\_\_\_\_ Attention to: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Fax: \_\_\_\_\_

**Information to be released:**

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

Date(s) of service From: \_\_\_\_\_ To: \_\_\_\_\_

Description of information to be released: (check all that apply)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Discharge Summary                          | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Physician Orders            | <input type="checkbox"/> Cardiology      |
| <input type="checkbox"/> Emergency Dept                             | <input type="checkbox"/> Radiology Report  | <input type="checkbox"/> Rehab PT/OT/ST              | <input type="checkbox"/> X-ray films/CD  |
| <input type="checkbox"/> Urgent Care                                | <input type="checkbox"/> Pathology         | <input type="checkbox"/> Chart Summary               | <input type="checkbox"/> Billing records |
| <input type="checkbox"/> History & Physical                         | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Progress Notes/Office notes |  |
| <input type="checkbox"/> Abstract (summary of visits and all tests) | <input type="checkbox"/> Consultations     | <input type="checkbox"/> Immunizations               |  |
| <input type="checkbox"/> Other _____                                |  |  |  |

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

- |  |  |
|--|--|
| <input type="checkbox"/> Drug and Alcohol testing and/or treatment Records | <input type="checkbox"/> HIV/AIDS/STD testing and/or treatment Records |
| <input type="checkbox"/> Psychiatric Evaluation                            | <input type="checkbox"/> Mental Health Progress Notes                  |
| <input type="checkbox"/> Treatment Plan                                    | <input type="checkbox"/> Medication History                            |
| <input type="checkbox"/> Intake Assessment                                 | <input type="checkbox"/> Evaluations                                   |

**Purpose of release (Why is it needed)**

- Continuing Care  Transfer of Care  Personal Use/Review  Insurance  Workers Compensation  
 Attorney  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 2.

**Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition:** \_\_\_\_\_

I understand that 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 #** \_\_\_\_\_

**Visit ID** \_\_\_\_\_

**Telephone request ( ) Date:** \_\_\_\_\_

**Charge: Yes Or No**

**By Whom:** \_\_\_\_\_

**Info to be ( ) Faxed ( ) Mailed ( ) Picked up ( ) Handed**

**Date/Time to be mailed, etc:** \_\_\_\_\_

**Date Completed:** \_\_\_\_\_

North Country Healthcare  
Littleton Regional Healthcare  
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Littleton, NH 03561