

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: _____
Patient's Address: _____
City, State, Zip: _____
Telephone Number: (____) ____-____ SSN: _____ DOB: _____

Littleton Regional Healthcare
Health Information Management
600 St. Johnsbury Road
Littleton, New Hampshire 03561
Questions: Hospital 603.444.9538
Practices: 603.259.7745
FAX Number: 603.259.7559

Release of Information FROM Littleton Regional Healthcare

Release of Information TO Littleton Regional Healthcare

____ I authorize Littleton Regional Healthcare to release copies of my record as listed below. The information is to be **sent to**:

____ I authorize the release of information **from** the party listed below **to be sent to** Littleton Regional Healthcare:

Name of Physician, Institution, Hospital, Self, etc.

Name of Physician, Institution, Hospital, Self, etc.

OR

Address

Address

City, State, Zip

City, State, Zip

(____) ____-____ (____) ____-____
Telephone Number Fax Number

(____) ____-____ (____) ____-____
Telephone Number Fax Number

Dates Of Treatment: What dates of treatment do you need records for? Date: _____
You **must** list specific dates of service, hospitalization, treatment, etc.

Information To Be Released	
<input type="checkbox"/> Anesthesia Record	<input type="checkbox"/> Physician Practice Records
<input type="checkbox"/> ED Records	<input type="checkbox"/> EKG
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultation(s)
<input type="checkbox"/> Laboratory	<input type="checkbox"/> History & Physical
<input type="checkbox"/> Nursing Notes	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Entire Medical Record for specific date(s) of service
<input type="checkbox"/> Stress Test/Cardiology	<input type="checkbox"/> Other, please be specific: _____
<input type="checkbox"/> Pathology	_____
<input type="checkbox"/> Pulmonary Function Test	_____
<input type="checkbox"/> Rehab/PT/OT/ST	
<input type="checkbox"/> X-Ray/Diagnostic Imaging	

Information to be released from PHYSICIAN PRACTICES
<input type="checkbox"/> Entire Practice Record for specific date(s) of service listed
<input type="checkbox"/> Other, please be specific or list to left: _____
Sensitive Information
<input type="checkbox"/> Drug and Alcohol Treatment Records
<input type="checkbox"/> Mental Health Records
<input type="checkbox"/> Psychotherapy Notes
<input type="checkbox"/> HIV/AIDS Testing and/or Treatment Records

Reason For Disclosure/Purpose
<input type="checkbox"/> Attorney Request
<input type="checkbox"/> Billing Purposes
<input type="checkbox"/> Continuation of Care
<input type="checkbox"/> Deposition
<input type="checkbox"/> Disability Claim
<input type="checkbox"/> Insurance Claim
<input type="checkbox"/> Social Security Request
<input type="checkbox"/> Worker's Compensation Claim
<input type="checkbox"/> Other (please specify below): _____

REVOCACTION: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department or send by certified mail to the address above. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I have questions about the disclosure of health information, I can contact Health Information Management Department by calling (603) 444-9538.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure by the receiving party. I understand that, once disclosed to the receiving party, this information may no longer be protected by federal confidentiality rules.

MARKETING: This authorization permits the use & disclosure of healthcare information for marketing purposes. No Yes
HOSPITAL USE ONLY: Patient will receive remuneration from a third party for the use of this healthcare information. No Yes

DISCUSSION/TESTIMONY/AFFIDAVITS: I authorize the following individuals to discuss with me and/or _____ and to testify or give sworn affidavits as to whatever s/he knows about my illness, injuries and treatment, as referenced on this form.
 Any and all practitioners involved in my care Other LRH staff Other _____

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 if I wish to change.

Signature of: Patient Legal Representative _____ Date _____ Signature of Witness _____ Date _____
If signed by Legal Representative, please indicate relationship to patient: Durable Power of Attorney for Health Care Legal Guardian Parent



PHOTOCOPYING CHARGES FOR MEDICAL RECORDS

TO OUR PATIENTS:

Federal law (§164.524(c)(4)(i)) permits healthcare providers to charge reasonable cost-based fees for photocopying of medical records. This includes the cost of supplies, labor and postage fees (if mailed). Federal law does not permit the charging of retrieval fees to the individual patient. Retrieval fees are allowed for all other requestors.

New Hampshire state law (RSA 151:21,X and RSA 332-l:1,i) places a maximum cap of \$0.50 cents per page with a maximum allowable charge of \$15 for the first 30 pages. Charges must be at a reasonable cost if records are stored on microfilm, microfiche, photos or videotape.

Littleton Regional Healthcare will charge no retrieval fee to the patient and will charge a maximum of \$0.50 cents per page for paper records or \$0.75 cents per page plus postage for records stored on "film." A copy of our fee schedule is listed below for your convenience. CHECKS ACCEPTED ONLY made payable to Littleton Regional Healthcare.

We are SORRY, as we cannot accept CASH

REQUESTOR	EMR or PAPER RECORDS
Patient	\$0.50 per page
Attorney	\$15 for first 30 pages, \$0.50 per page thereafter
Insurance Company	\$15 for first 30 pages, \$0.50 per page thereafter
Billing Office (Internal)	No Charge
Healthcare Provider (physician)	No Charge
CD or Electronic Delivery	\$0.25 per page & \$2.00 E-Delivery charge
Other	\$15 for first 30 pages, \$0.50 per page thereafter

OFFICE USE ONLY

Date Authorization Received: _____

Identifiers: Medical Record # _____ Visit ID# _____ DOB _____

Date Information Copied: _____ Information Released By (Name): _____

Information Released (Cannot Be More Than Allowed By This Signed Authorization): _____

Number of Page(s) Copied: _____ Charge(s)(if any): _____

Mode of Release: In Person By US Mail By Fax# _____ - _____ - _____

Electronic CD FedEx Other Alternative Method _____

Tracking #, if available: _____

Personal Identification Verified (Do Not Record): Driver's License Military ID Badge Other Picture ID

****This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any Alcohol or Drug abuse patient. (42 CFR 2.32).**

Patient Identification
