NCH north country healthcare | Littleton Regional Healthcare

600 St Johnsbury Road
Littleton, NH 03561
Phone: 603-444-9538

AUTHORIZATION FOR RELEASE OF INFORMATION

Print Patient Name Maiden Name Date of Birth Med Rec Number

Address City State Zip Phone #

I hereby authorize Littleton Regional Healthcare to **DISCLOSE / RECEIVE** (circle one) my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.
The health information described herein shall be released to / from: ___Hospital/Other Facility; ___Physician;
____ Insurance Company; ___ Attorney; ___ Patient; ___ Other: _____

Individual / Entity

Address City State Zip

_____ _____
Phone Number Fax Number

Re-disclosure: I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

Date(s) of Service: From _____ ---- To _____

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

____ Discharge Summary	____ Laboratory Report	____ Physician Orders	____ Ambulance
____ Emergency Dept.	____ Radiology Report	____Rehab PT/OT/ST	____ Other: _____
____ Walk In Clinic	____ Pathology	____ Immunizations	____ Chart Summary
____ History & Physical	____ Operative Reports	____ Billing records	_____
____ Consultation Report	____ Progress Notes	____ X-ray films	_____

Sensitive Information (initial to be released)

____ Drug and Alcohol testing and/or treatment Records		____ HIV/AIDS/STD testing and/or treatment Records	
____ Psychiatric Evaluation		____ Mental Health Progress Notes	
____ Treatment Plan	____Medication History	____ Intake Assessment	____ Evaluations

Purpose of Disclosure:

____Temporary transfer of care (College/winter away)		____ Permanent Transfer of Care (effective Date)_____	
____Continuation of Care	____Insurance	____ Workers Compensation	____ Other
____At the Request of the Patient			

Expiration: I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____.
Expiration event/date

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 LRH Staff _____ Other:_____

Revocation: I further understand that I may revoke this authorization at any time by notifying Littleton Regional Healthcare in writing at the address specified above. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken in reliance on this authorization before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date
Witness:_____ ***By Whom:*** _____
Info to be ( )Faxed ( ) Mailed ( ) Picked up ( ) Handed
Telephone Request ( ) Date: _____ **Date/Time to be mailed, etc;**_____
Charge: Yes Or NO **Date Completed:**_____
By Whom:_____

**** 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 whom it pertains or as otherwise permitted by (42 CFR Part 2)