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

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

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

____
Address

____
City, State, Zip

(_____) ______-__________ (_____) ______-__________
Telephone Number Fax Number

OR

Release of Information TO Littleton Regional Healthcare

___ 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.

____
Address

____
City, State, Zip

(_____) ______-__________ (_____) ______-__________
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

- ○ Anesthesia Record
- ○ ED Records
- ○ Discharge Summary
- ○ Laboratory
- ○ Nursing Notes
- ○ Physician Orders
- ○ Stress Test/Cardiology
- ○ Pathology
- ○ Pulmonary Function Test
- ○ Rehab/PT/OT/ST
- ○ X-Ray/Diagnostic Imaging
- ○ Physician Practice Records
- ○ EKG
- ○ Consultation(s)
- ○ History & Physical
- ○ Operative Report
- ○ Entire Medical Record for specific date(s) of service
- ○ Other, please be specific:

____

____

Information to be released from **PHYSICIAN PRACTICES**

- ○ Entire Practice Record for specific date(s) of service listed
- ○ Other, please be specific or list to left:

____

Sensitive Information

- ○ Drug and Alcohol Treatment Records
- ○ Mental Health Records
- ○ Psychotherapy Notes
- ○ HIV/AIDS Testing and/or Treatment Records

Reason For Disclosure/Purpose

- ○ Attorney Request
- ○ Billing Purposes
- ○ Continuation of Care
- ○ Deposition
- ○ Disability Claim
- ○ Insurance Claim
- ○ Social Security Request
- ○ Worker's Compensation Claim
- ○ Other (please specify below):

____

REVOCATION: 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-I: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