Permission of LRH to Discuss Treatment Information with Family, Friends, and Other Designated Individuals

Patient Name (print): _____ Date of Birth: _____

I give Littleton Regional Healthcare (LRH) and its providers permission to discuss information regarding my medical care and treatment at LRH with the person(s) listed below. I understand that if I want to stop sharing information with these person(s), I must notify LRH in writing of my intent to revoke this form. I understand this form only covers oral disclosures of protected health information (PHI) and that I will need to execute LRH's standard medical records authorization form in order for LRH to disclose copies of my medical records to the individuals designated below or others.

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Please initial the items below for which LRH is allowed to orally share information:

_____ Medical care and appointments

_____ Billing information

_____ Information containing drug/alcohol abuse excluding records from the LRH Doorway of any other LRH drug/alcohol treatment programs, mental health information excluding information from psychotherapy notes, HIV, and/other genetic testing information.

_____ Other (please specify) _____

Please indicate any limitations or restrictions on the general right of LRH to disclose information regarding your care and treatment: _____

_____

Patient/Legal Guardian Signature: _____ Date: _____ Time: _____

Patient/Legal Guardian Printed Name: _____

Littleton Regional Healthcare
600 St. Johnsbury Road
Littleton, NH 03561