

**Transferring Care FROM Littleton Regional Healthcare Authorization Form**

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.

Name: \_\_\_\_\_ Previous Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I Authorize**

Littleton Regional Healthcare  
Health Information Dept  
600 St. Johnsbury Rd., Littleton, NH 03561  
 Phone: 603-444-9358 Fax: 603-259-7559

**To release  
 my  
 medical  
 records to:**

**The following Facility/Provider:**

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

Fax: \_\_\_\_\_

**I would like to transfer the following records:**

- |   |   |
|---|---|
| _____ Physician Office Visit(s) <b>Past 2 years</b> | _____ Laboratory Report <b>Last 2 years</b> |
| _____ Patient Chart Summary                         | _____ Pathology <b>ALL dates</b>            |
| _____ Radiology Reports <b>ALL dates</b>            | _____ Immunizations <b>ALL dates</b>        |
| _____ Operative Reports <b>ALL dates</b>            | _____ Inpatient Stay(s) <b>Past 2 years</b> |
| _____ Emergency Room Visit(s) <b>Past 2 years</b>   | _____ Rehab PT/OT/ST <b>Past 2 years</b>    |
| _____ Cardiology/EKG <b>ALL dates</b>               |   |

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

- \_\_\_\_\_ Drug and Alcohol testing and/or treatment records **Past 2 years**
- \_\_\_\_\_ HIV/AIDS/STD testing and/or treatment records **Past 2 years**
- \_\_\_\_\_ Psychiatric Evaluation **Past 2 years**
- \_\_\_\_\_ Mental Health Progress Notes **Past 2 years**
- \_\_\_\_\_ Intake Assessment **Past 2 years**

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



**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 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 # \_\_\_\_\_ eCW# \_\_\_\_\_ Alpine# \_\_\_\_\_

Visit ID \_\_\_\_\_ Number of Pages \_\_\_\_\_ Number of Pages \_\_\_\_\_

Number of Pages \_\_\_\_\_

Completed by \_\_\_\_\_

Records to be ( ) Faxed ( ) Mailed ( ) Picked Up ( ) Handed ( ) E-mail

Radiology images to be ( ) Shared with Nucleus ( ) Export to CD

Date completed \_\_\_\_\_

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