

Authorization For Release Of Information

Health Information Management Dept.

**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.**

600 St. Johnsbury Road
Littleton, NH 03561
Phone: 603-444-9538 Fax: 603-259-7559

<p>Please Print Patient Information <i>must be fully completed</i></p>	<p>Name: _____ Previous Name: _____ Date of Birth: _____</p> <p>Address: _____ Phone: _____</p> <p>City: _____ State: _____ Zip Code: _____</p>																										
<p>Who has the information you want released.</p>	<p style="text-align: center;">Please list the specific hospital, physician office and/or home health agency</p> <p>Provider / Facility: _____</p> <p>Address: _____ Phone: _____</p> <p>City: _____ State: _____ Zip Code: _____ Fax: _____</p>																										
<p>Who do you want to receive your information?</p>	<p>I hereby authorize the above named facility/provider to:</p> <div style="float: right;"> <input type="checkbox"/> Release medical records, <input type="checkbox"/> Speak to/discuss with, <input type="checkbox"/> Both release medical records to and discuss medical information with </div> <p>Provider / Facility / Person: _____</p> <p>Address: _____ Phone: _____</p> <p>City: _____ State: _____ Zip Code: _____ Fax: _____</p> <p>Email: _____</p>																										
<p>Information to be released:</p> <p>What do you want shared? Check appropriate boxes.</p>	<p>Date(s) of service From: _____ To: _____</p> <p style="text-align: center;"><u>We do not accept "ALL" for dates of service. If left blank the last 2 years will be sent.</u></p> <p style="text-align: center;">Check off the information you would like to be sent:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Abstract (summary of visits and all tests)</td> <td><input type="checkbox"/> Urgent Care</td> </tr> <tr> <td><input type="checkbox"/> Emergency Room Visit(s) (Reports, tests, consults, etc.)</td> <td><input type="checkbox"/> Cardiology Reports and Stress Tests</td> </tr> <tr> <td><input type="checkbox"/> Physician Office Visit(s)</td> <td><input type="checkbox"/> Pathology</td> </tr> <tr> <td><input type="checkbox"/> Radiology Reports</td> <td><input type="checkbox"/> Rehab PT/OT/ST</td> </tr> <tr> <td><input type="checkbox"/> Laboratory Report</td> <td><input type="checkbox"/> Billing Records</td> </tr> <tr> <td><input type="checkbox"/> Operative Report</td> <td>Other _____</td> </tr> <tr> <td><input type="checkbox"/> Immunizations</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Inpatient Stay(s)</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Nursing Notes</td> <td>_____</td> </tr> </table> <p style="text-align: center;">*Radiology Images will be available through Nucleus Online Portal.</p> <p>Sensitive Information (INITIAL to be released)</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Drug & Alcohol testing and/or treatment records</td> <td><input type="checkbox"/> HIV/AIDS/STD testing and/or treatment records</td> </tr> <tr> <td><input type="checkbox"/> Psychiatric Evaluation</td> <td><input type="checkbox"/> Treatment Plan</td> </tr> <tr> <td><input type="checkbox"/> Intake Assessment</td> <td><input type="checkbox"/> Mental Health Progress Notes</td> </tr> <tr> <td><input type="checkbox"/> Evaluations</td> <td></td> </tr> </table>	<input type="checkbox"/> Abstract (summary of visits and all tests)	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> Emergency Room Visit(s) (Reports, tests, consults, etc.)	<input type="checkbox"/> Cardiology Reports and Stress Tests	<input type="checkbox"/> Physician Office Visit(s)	<input type="checkbox"/> Pathology	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Rehab PT/OT/ST	<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Operative Report	Other _____	<input type="checkbox"/> Immunizations	_____	<input type="checkbox"/> Inpatient Stay(s)	_____	<input type="checkbox"/> Nursing Notes	_____	<input type="checkbox"/> Drug & Alcohol testing and/or treatment records	<input type="checkbox"/> HIV/AIDS/STD testing and/or treatment records	<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Intake Assessment	<input type="checkbox"/> Mental Health Progress Notes	<input type="checkbox"/> Evaluations	
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FOR LEGAL USE ONLY

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 staff _____ Other: _____

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 1.

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 _____

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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 _____

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