LITTLETON REGIONAL HEALTHCARE

Authorization For Release Of Information

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.

Health Information Management Dept.
600 St. Johnsbury Road
Littleton, NH 03561
Phone: 603-444-9538 Fax: 603-259-7559
Email HIMdept@lrhcares.org

Please Print Patient Information *must be fully completed*

Name:_____ Previous Name:_____ Date of Birth: _____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code: _____

Who has the information you want released.

Please list the specific hospital, physician office and/or home health agency

Provider / Facility: _____

Address:_____ Phone: _____

City:_____ State:_____ Zip Code:_____ Fax: _____

Who do you want to receive your information?

I hereby authorize the above-named facility/provider to: (Please Initial) ____ Release medical records, ____ Speak to/discuss with, ____ Both release medical records to and discuss medical information with

Provider / Facility: _____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____ Fax:_____

Email: _____

Information to be released:

What do you want shared? Check **appropriate** boxes.

Date(s) of service from: _____ To: _____

We do not accept "ALL" for dates of service. If left blank the last 2 years will be sent.

Check off the information you would like to be sent:

___ Abstract (summary of visits and all tests)
__ Emergency Dept. Visit(s) (Reports, tests, consults, etc.)
__ Physician Office Visit(s)
___ Radiology Reports
___ Laboratory Report
__ Operative Report
___ Immunizations
__ In patientStay(s)
__ Nursing Notes

___Radiology Images
****Radiology Images will be available through Nucleus Online Portal.***

_Urgent Care
_Cardiology Reports and Stress Tests
_Pathology
_Rehab PT/OT/ST
_Billing Records
Other_____
_____

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

_ _Drug & Alcohol testing and/or treatment records
___Psychiatric Evaluation
— _ Intake Assessment
— —Treatment Plan
— —Evaluations
__HIV/AIDS/STD testing and/or treatment records
__Mental Health Progress Notes

Purpose of Release (Why it is needed)

☐ Continuing Care ☐ Attorney ☐ Transfer of Care ☐ Workers Compensation ☐ Personal Use/Review ☐ Temporary Transfer of Care (school winter /away) ☐ Insurance ☐ Other (specify): _____

Fees may be charged in accordance with State and Federal Statutes

Revised 10.10.25 Forms Committee Approved 10.10.25

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 of Authorized Representative _____

Printed Name _____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney) _____

Date_____Time _____

For Office Use Only

Medical Record #_____ **ID verification __ Driver License __ School ID __Other: _____**

Cerner FIN_____ **Paragon Visit ID**_____

Number of Pages _____ **Number of Pages**_____

eCW#_____ **Alpine#**_____

Number of Pages _____ **Number of Pages** _____

Completed by _____

Records to be ( ) Faxed ( ) Mailed ( ) Picked Up ( ) Handed ( ) E-mail ( ) Share File/Portal

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

Date completed _____

Patient Identification
Name:
DOB:
MRN:
FIN:

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

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