LITTLETON REGIONAL HEALTHCARE

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

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 30 days to process.

Please Print Patient Information Must be fully completed	Name: _____ Precious 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:** ____ Emergency Dept. Visits(s) (Reports, tests, consults, etc.) ____ Physician Office Visit(s) ____ Radiology Reports ____ Laboratory Report ____ Operative Report ____ Immunizations ____ Inpatient stay(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 ☐ Transfer of Care ☐ Personal Use/Review ☐ Insurance ☐ Attorney ☐ Workers Compensation ☐ Temporary Transfer of care (school winter/away) ☐ Other (Specify) _____ **Fees may be charged in accordance with State and Federal Statutes**

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FOR LEGAL USE ONLY

Discussion/Testimony/Affidavits: I authorize the following individuals to discuss with me and/or _____
And 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 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 basis for denial of health benefits or 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 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 explanation 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 Littleton Regional Healthcare I wish to change.

Signature of Patient or Authorized Representative: _____

Print 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 ( ) Emailed ( ) Share File/Portal

Radiology Images to be shared ( ) Shared with Nucleus ( ) Export to CD

Date Completed: _____/_____/_____

Patient Identification
Name:
DOB:
MRN:
FIN:

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