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 to 30 days to process.

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, for purposes permitted by 42 CFR Part 2 and HIPAA, the above-named facility/provider to: **(Please Initial all that apply)** _____ Release medical records, _____ Speak to/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: ________ **<u>We do not accept “ALL” for dates of service. If left blank the last 2 years will be sent.</u>** **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 (excluding Substance Use Disorder Counseling Notes) ____ Psychiatric Evaluation ____ Treatment Plan ____ Mental Health Progress Notes ____ Intake Assessment ____ Evaluations ____ Substance Use Disorder Counseling Notes ____ HIV / AIDS / STD testing and/or treatment records
Purpose of Release (Why it is needed?)	☐ Continuing Care ☐ Transfer of Care ☐ Personal Use/Review ☐ Insurance ☐ Attorney ☐ Worker’s 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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Patient Name: ______________________________ Date of Birth: _____/_____/_______

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, as permitted or required by law.
- I understand that whenever records are disclosed based on this Authorization, the disclosure must be accompanied by this Authorization or an explanation of its scope.
- 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 expiration date, event or condition, this authorization will expire 6 months from the date signed. I also understand it is my responsibility if I document a longer expiration date, I need to cancel by writing to Littleton Regional Healthcare if I wish to change that date.

- This Authorization does not permit disclosure of Substance Use Disorder Counseling Notes, unless indicated above.
- This Authorization does not permit use or disclosure of any records for civil , criminal, administrative, or legislative proceedings, or for investigation or action against me.

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: