AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: _____

Patient's Address: _____

City, State, Zip: _____

Telephone Number (____) _____-_____ SSN _____ DOB: _____

Littleton Regional Healthcare
Health Information Management
600 St. Johnsbury Road
Littleton, New Hampshire 03561
Questions: Hospital 603.444.9538
Practices: Please inquire with the practice where your release was completed

Release of Information FROM Littleton Regional Healthcare

___ I authorize Littleton Regional Healthcare to release copies of my record as listed below. The information is to be **sent to**:

_____
Name of Physician, Institution, Hospital, Self, etc.

_____
Address

_____
City, State, Zip

(_____) _____-_____ (_____) _____-_____
Telephone Number Fax Number

OR

Release of Information TO Littleton Regional Healthcare

___ I authorize the release of information **from** the party listed below **to be sent to** Littleton Regional Healthcare:

_____
Name of Physician, Institution, Hospital, Self, etc.

_____
Address

_____
City, State, Zip

(_____) _____-_____ (_____) _____-_____
Telephone Number Fax Number

Dates Of Treatment - What dates of treatment do you need records for? Date: _____
You **must** list specific dates of service, hospitalization, treatment, etc.

Information To Be Released

- ○ Anesthesia Record
- ○ ED Records
- ○ Discharge Summary
- ○ Laboratory
- ○ Nursing Notes
- ○ Physician Orders
- ○ Stress Test/Cardiology
- ○ Pathology
- ○ Pulmonary Function Test
- ○ Rehab/PT/OT/ST/Cardiac
- ○ X-Ray/Diagnostic Imaging
- ○ EKG
- ○ Consultation(s)
- ○ History & Physical
- ○ Operative Report
- ○ Entire Medical Record for specific date(s) of service
- ○ Other (please be specific:

_____

_____

Information to be released from **PHYSICIAN PRACTICES**

- ○ Entire Practice Record for specific date (s) of service listed
- ○ Other (please be specific or list to left)

_____

Sensitive Information

- ○ Drug and/or Alcohol Treatment Records
- ○ Mental Health Records
- ○ HIV/AIDS Testing and/or Treatment Records

Reason For Disclosure/Purpose

- ○ Attorney Request
- ○ Billing Purposes
- ○ Continuation of Care
- ○ Deposition
- ○ Disability Claim
- ○ Insurance Claim
- ○ Social Security Request
- ○ Worker's Compensation Claim
- ○ Other (please specify below):

_____

REVOCATION: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department or send by certified mail to the address above. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I have questions about the disclosure of health information, I can contact Health Information Management Department by calling (603) 444-9538.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure by the receiving party. I understand that, once disclosed to the receiving party, this information may no longer be protected by federal confidentiality rules.

MARKETING: This authorization permits the use & disclosure of healthcare information for marketing purposes. ○ **No** ○ **Yes**
HOSPITAL USE ONLY: Patient will receive remuneration from a third party for the use of this healthcare information. ○ **No** ○ **Yes**

DISCUSSION/TESTIMONY/AFFIDAVITS: I authorize the following individuals to discuss with me and/or _____ and to testify or give sworn affidavits as to whatever s/he knows about my illness, injuries and treatment, as referenced on this form.

○ **Any and all practitioners involved in my care** ○ **Other LRH staff** ○ **Other**_____

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
I understand that 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 if I wish to change.

_____ _____ _____ _____
Signature of ○ **Patient** ○ **Legal Representative** **Date** **Signature of Witness** **Date**

If signed by Legal Representative, please indicate relationship to patient: ○ **Durable Power of Attorney for Health Care** ○ **Legal Guardian** ○ **Parent**