

AUTHORIZATION FOR RELEASE OF INFORMATION

Print Patient Name Maiden Name Date of Birth Med Rec Number

Address City State Zip Phone #

I hereby authorize Littleton Regional Healthcare to **DISCLOSE / RECEIVE** (circle one) my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

The health information described herein shall be released to / from: ___ Hospital/Other Facility; ___ Physician; ___ Insurance Company; ___ Attorney; ___ Patient; ___ Other: _____

Individual / Entity

Address City State Zip

Phone Number Fax Number

Re-disclosure: I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

Date(s) of Service: From _____ To _____

Description of information to be released: (check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Ambulance |
| <input type="checkbox"/> Emergency Dept. | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Rehab PT/OT/ST | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Walk In Clinic | <input type="checkbox"/> Pathology | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Chart Summary |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Billing records | _____ |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-ray films | _____ |

Sensitive Information (initial to be released)

- | | |
|--|--|
| <input type="checkbox"/> Drug and 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"/> Mental Health Progress Notes |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Medication History |
| | <input type="checkbox"/> Intake Assessment |
| | <input type="checkbox"/> Evaluations |

Purpose of Disclosure:

- | | |
|---|--|
| <input type="checkbox"/> Temporary transfer of care (College/winter away) | <input type="checkbox"/> Permanent Transfer of Care (effective Date) _____ |
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> At the Request of the Patient | <input type="checkbox"/> Workers Compensation |
| | <input type="checkbox"/> Other |

Expiration: I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.
Expiration event/date

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 LRH Staff ___ Other: _____

Revocation: I further understand that I may revoke this authorization at any time by notifying Littleton Regional Healthcare in writing at the address specified above. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken in reliance on this authorization before the receipt of the written revocation.

Signature of Patient or Patient's Representative
Witness: _____

Date
By Whom: _____

Telephone Request () Date: _____
Charge: Yes Or NO
By Whom: _____

Info to be () Faxed () Mailed () Picked up () Handed
Date/Time to be mailed, etc; _____
Date Completed: _____

**** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by (42 CFR Part 2)