Transferring Care FROM Littleton Regional Healthcare Authorization Form

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.

Name:______________________________ Previous Name:____________________

Date of birth:______________________________ Phone: ____________________

Address: ____

City:______________________________ State: ____________ Zip: ________

I Authorize		**The following Facility/Provider:**
Littleton Regional Healthcare Health Information Dept 600 St. Johnsbury Rd., Littleton, NH 03561 Phone: 603-444-9358 Fax: 603-259-7559	**To release my medical records to:**	____________________ Address: ____________________ ____________________ Phone:____________________ Fax: ____________________

I would like to transfer the following records:

________ Physician Office Visit(s) **Past 2 years**
________ Patient Chart Summary
________ Radiology Reports **ALL dates**
________ Operative Reports **ALL dates**
________ Emergency Room Visit(s) **Past 2 years**
________ Cardiology/EKG **ALL dates**
________ Laboratory Report **Last 2 years**
________ Pathology **ALL dates**
________ Immunizations **ALL dates**
________ Inpatient Stay(s) **Past 2 years**
________ Rehab PT/OT/ST **Past 2 years**

Sensitive Information: (INITIAL to be released)

________ Drug and Alcohol testing and/or treatment records **Past 2 years**
________ HIV/AIDS/STD testing and/or treatment records **Past 2 years**
________ Psychiatric Evaluation **Past 2 years**
________ Mental Health Progress Notes **Past 2 years**
________ Intake Assessment **Past 2 years**

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

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 2.

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 #____________________ **eCW#** ____________________ **Alpine#** ____________________
Visit ID ____________________ **Number of Pages** __________ **Number of Pages**__________
Number of Pages ______________

Completed by ____
Records to be ( ) Faxed ( ) Mailed ( ) Picked Up ( ) Handed ( ) E-mail

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

Date completed ______________________________

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