Transferring Care INTO 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:

_____

Address: _____

_____

Phone: _____

Fax: _____

To release my medical records to:

Littleton Regional Healthcare
Health Information Dept
600 St. Johnsbury Rd., Littleton, NH 03561
Phone: 603-444-9358 Fax: 603-259-7559

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 _____

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