



One Elliot Way  
Manchester, NH 03103

**RELEASE OF HEALTHCARE INFORMATION**

**PATIENT IDENTIFICATION**

NAME: \_\_\_\_\_ DATE of BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE: \_\_\_\_\_

**AUTHORIZATION TO:**

Release Patient Information To: \_\_\_\_\_  
Address: \_\_\_\_\_  
 Released From: \_\_\_\_\_  
Address: \_\_\_\_\_

**PATIENT INFORMATION TO BE RELEASED:** (Check all that apply)

ER  H & P  \*Sensitive Information  Other \_\_\_\_\_  
 Consult  Operative Report \_\_\_\_\_  \*Mental Health  
 X-Ray  Discharge Summary \_\_\_\_\_  \*Alcohol Abuse/Treatment  
 Lab  Progress Note \_\_\_\_\_  \*Drug Abuse/Treatment  
 Abstract  Complete Medical Record \_\_\_\_\_  \*HIV Diagnosis/Treatment

**DATES OF SERVICE TO BE RELEASED:** From: \_\_\_\_\_ To: \_\_\_\_\_

**INFORMATION TO BE:**  Picked Up  Electronic – CD  
 Mailed  Electronic – Flash Drive  
 Faxed (see fax release notice below) –

\*Fax Release Notice. I am aware that the above requested information is to be released via a fax machine. I am also aware of the risks associated with faxing protected health information, and \*sensitive information, including but not limited to: erroneous transmission, lack of confidentiality safeguards at the site of the receiving machine and incomplete transmission information.

**PURPOSE** for which this information is being released: (check one)

Continued Medical Care  Legal  Permanent Transfer to Another Provider  
 Insurance  Personal  Consultation with Specialist  
 Other

**POST-ACUTE CARE PROVIDERS:** I have been given a list of post-acute care providers and have had my options explained to me.

I agree to use the “preferred provider” my insurance coverage mandates.  
 I have selected my post-acute care provider and my choice is stated above.

**I UNDERSTAND THAT:**

The information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to re-disclosure and may no longer be protected by federal and state confidentiality laws. I may revoke this authorization at any time in writing, provided the information has not already been disclosed in reliance on this authorization. Additional details may be found in the Elliot Health System Notice of Privacy Practices.

I know that this authorization is voluntary, and I may refuse to sign this form. I understand that refusing to sign this form will not affect my ability to obtain treatment from Elliot Health System, the payment for my treatment, or my enrollment or eligibility for benefits unless allowed by law.

**There is a fee for copies of records, regulated by NH state law.**

I have read this entire form or have had it read to me. I understand the content. I hereby authorize the release of my patient information stated above and release Elliot Health System from any legal responsibility or liability relating to the release of information. This authorization is considered valid for a period of one year from the date of signature or until (date) \_\_\_\_\_.

\_\_\_\_\_  
Patient/Parent/Legal Agent Signature Date Event

\_\_\_\_\_  
Identification (if other than patient)

