

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)

<input type="checkbox"/> ER	<input type="checkbox"/> H & P	<input type="checkbox"/> *Sensitive Information	<input type="checkbox"/> Other _____
<input type="checkbox"/> Consult	<input type="checkbox"/> Operative Report	_____ <input type="checkbox"/> *Mental Health	
<input type="checkbox"/> X-Ray	<input type="checkbox"/> Discharge Summary	_____ <input type="checkbox"/> *Alcohol Abuse/Treatment	
<input type="checkbox"/> Lab	<input type="checkbox"/> Progress Note	_____ <input type="checkbox"/> *Drug Abuse/Treatment	
		_____ <input type="checkbox"/> *HIV Diagnosis/Treatment	

DATES OF SERVICE TO BE RELEASED: From: _____ To: _____

INFORMATION TO BE: Picked Up
 Mailed
 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)

<input type="checkbox"/> Continued Medical Care	<input type="checkbox"/> Legal
<input type="checkbox"/> Insurance	<input type="checkbox"/> Personal
<input type="checkbox"/> 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 is subject to re-disclosure and may no longer be protected by federal privacy regulations. I may revoke this authorization at any time in writing or verbally, if followed by written confirmation.

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 ninety days from the date of signature. The date of this authorization must not precede the date(s) of service that is requested.

Patient/Parent/Legal Agent Signature _____
Date

Identification (if other than patient)