

Authorization For Release Of Information

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.

59 Page Hill Road
Berlin, NH 03570
Phone: 603-752-2200

Please Print Patient Information must be fully completed

Name: _____ Previous name: _____ Date of Birth _____
Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____

Who has the information you want released.

Provider: _____

Please list the specific hospital, physician office and/or home health agency

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Who do you want to receive your information

I hereby authorize the above-named hospital/physician office to:

Release medical records, to Speak to/discuss with, Both release medical records to and discuss medical information with,

Name: _____ Attention to: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Information to be released:

Date(s) of service From: _____ To: _____
Description of information to be released: (check all that apply)

What do you want shared? Check appropriate boxes

- | | | | |
|---------------------------------------------------------------------|--------------------------------------------|------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Cardiology |
| <input type="checkbox"/> Emergency Dept | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Rehab PT/OT/ST | <input type="checkbox"/> X-ray films/CD |
| <input type="checkbox"/> Urgent Care | <input type="checkbox"/> Pathology | <input type="checkbox"/> Chart Summary | <input type="checkbox"/> Billing records |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Progress Notes/Office notes | |
| <input type="checkbox"/> Abstract (summary of visits and all tests) | <input type="checkbox"/> Consultations | <input type="checkbox"/> Immunizations | |
| <input type="checkbox"/> Other _____ | | | |

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 release (Why is it needed)

- Continuing Care Transfer of Care Personal Use/Review Insurance Workers Compensation
 Attorney Temporary Transfer of care (school/winter away) Other (specify): _____

Fees may be charged in accordance with State and Federal Statutes

FOR LEGAL USE ONLY

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 Staff _____ Other: _____

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 that 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 Androscoggin Valley Hospital I wish to change.

Signature of Patient or Authorized Representative _____

Printed Name _____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney) _____

Date _____ **Time** _____

FOR OFFICE USE ONLY

Medical Record # _____

Visit ID _____

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: _____