AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **I hereby authorize the use or disclosure (release) of my protected health information as described below.** I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations (45 CFR Part 164).

2. Littleton Regional Hospital or ______________________________ is authorized to
   Name of Specific Physician Office or Other Individual

   ☐ **USE/RELEASE TO** or ☐ **OBTAIN/RECEIVE FROM:**

   Person(s) or Facility Name:______________________________

   Street Address:______________________________

   City______________________________State______________ZIP______________

   The following information from the medical records of:

   ______________________________ ______________________________
   Patient's Name (Please Print) Patient's Date of Birth

3. **IN ADDITION,** I authorize ______________ to discuss with me and/or ______________ and to testify or give sworn affidavits as to whatever he/she knows about my illness, injuries and treatment, as referenced on this form.

4. Please specify or describe the information that you are requesting or choose from below:

		SENSITIVE INFORMATION:
☐ History & Physical	☐ Pathology Report	☐ Drug and/or Alcohol Treatment Records**
☐ Discharge Summary	☐ Consultation: Physician	☐ Mental Health Treatment Records
☐ Laboratory	☐ Physician Notes	☐ HIV/AIDS
☐ Radiology Reports	☐ Nurse's Notes	☐ Other: (Please Specify)
☐ Emergency Department	☐ EKG/Stress/Cardiology	______________
☐ Face Sheet	☐ Operative Report	______________
☐ Anesthesia Record	☐ Physical Therapy Notes	______________
☐ Physician's Orders	☐ Pulmonary Function Tests	

5. This authorization permits the use and disclosure of healthcare information for marketing purposes as described below.
   NO ☐ YES ☐ HOSPITAL USE ONLY: If the answer is YES, Littleton Regional Hospital WILL ☐ WILL NOT ☐ receive remuneration from a third party for the use of this healthcare information.

6. The information will be used or disclosed for the following purposes [ALL purposes must be listed and described]. If the information is for your personal use ONLY, please write "At my request" in the space below.

   PURPOSE 1:______________________________ PURPOSE 2:______________________________

7. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or determine eligibility for benefits unless allowed by law.

8. I understand that I may revoke this authorization at any time by notifying Littleton Regional Hospital in writing except to the extent that action has been taken in reliance on this authorization.

9. This authorization will expire on ______________(date) or on ______________(an event). If no date or event is specified, this authorization will be in effect for a period of six (6) months from the date affixed below. Upon conclusion of that time period (unless earlier revoked by me in writing), this authorization is automatically revoked. If this authorization is for a research study, the authorization will expire at the end of the research study.

10. I understand that Littleton Regional Hospital is permitted by law to impose photocopying fees of the requested information including the cost of supplies, labor, and postage (if mailed). I will be informed of the photocopying fees in advance of receiving copies of my medical record. Such fees are listed on the reverse side of this form. Receiving copies of my records will not be contingent upon my ability to pay these fees. Please allow up to 30 days to respond to a request for medical records or up to 60 days if records are not stored on hospital or clinic premises.

SIGNATURES

______________________________ ______________
Signature of patient or patient's authorized representative Date

______________________________ ______________
Printed name of patient or patient's authorized representative Relationship to patient and authority to act for the patient

PHOTOCOPYING CHARGES FOR MEDICAL RECORDS

TO OUR PATIENTS,
Federal law (§164.524(c)(4)(i) permits healthcare providers to charge reasonable cost-based fees for photocopying of medical records. This includes the cost of supplies, labor, and postage fees (if mailed). Federal law does not permit the charging of retrieval fees to the individual patient. Retrieval fees are allowed for all other requestors. New Hampshire state law (RSA 151:21,X and RSA 332-I:1, I) places a maximum cap of $0.50 cents per page plus postage with an allowable charge of $15 for the first 30 pages. Charges must be at a reasonable cost or if records are stored on microfilm, microfiche, photos, or videotape. Littleton Regional Hospital will charge no retrieval fee to the patient and will charge a maximum of $0.50 cents per page plus postage for paper records or $0.75 cents per page plus postage for records stored on "film." A copy of our fee schedule is listed below for your convenience. CHECKS ACCEPTED ONLY Made Payable to LITTLETON REGIONAL HOSPITAL. SORRY, NO CASH ACCEPTED.

REQUESTOR	PAPER RECORDS	FILMED RECORDS	RETRIEVAL FEE OFF-SITE ONLY
Patient	$0.50 per page plus postage	$0.75 per page plus postage	No Charge
Attorney	$15 for first 30 pages, $0.50 per page thereafter plus postage	$15 for first 30 pages, $0.75 per page thereafter plus postage	$10.00
Insurance Company	$15 for first 30 pages, $0.50 per page thereafter plus postage	$15 for first 30 pages, $0.75 per page thereafter plus postage	$10.00
Billing Office (Internal)	No Charge	No Charge	No Charge
Healthcare Provider (physician)	No Charge	No Charge	No Charge
Other	$15 for first 30 pages, $0.50 per page thereafter plus postage	$15 for first 30 pages, $0.75 per page thereafter plus postgе	$10.00
There is no additional charge for medical records that must be notarized.			

OFFICE USE ONLY

Date Authorization Received:____________________

Identifiers: ☐ Medical Record Number____________ ☐ SSN__________ ☐ DOB__________

Date Information Copied:____________________

Information Released By (Name):____________________

Information Released (Cannot Be More Than Allowed By This Authorization):____________________

____

Number of Page(s) Copied:____________ Charge(s)(if any):____________

Mode of Release: ☐ In Person ☐ By US Mail ☐ By Fax#___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

☐ FedEX ☐ Other Alternative Method____________________

Personal Identification Verified (Do Not Record): ☐ Driver's License ☐ Military ID ☐ Badge ☐ Other Picture ID

**This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any Alcohol or Drug abuse patient. (42 CFR 2.32).