AUTHORIZATION TO RELEASE INFORMATION

The Alpine Clinic
Health Information Management
1095 Profile Road
Franconia, New Hampshire 03580
Offices in Littleton, Woodsville, Plymouth, North Conway
Questions: 603.823.8600
FAX Number: 603.823.8688

Patient's Name: _____

Patient's Address: _____

City, State, Zip: _____

Telephone Number: (___) ____-____ SSN: _____ DOB: _____

Release of Information FROM Alpine Clinic

___ I authorize The Alpine Clinic to release copies of my record as listed below. The information is to be sent to:

_____
Name of Physician, Institution, Hospital, Self, etc.

_____
Address

_____
City, State, Zip

(___) ____-____ (___) ____-____
Telephone Number Fax Number

OR

Release of Information TO Alpine Clinic

___ I authorize the release of information from the party listed below to be sent to The Alpine Clinic:

_____
Name of Physician, Institution, Hospital, Self, etc.

_____
Address

_____
City, State, Zip

(___) ____-____ (___) ____-____
Telephone Number Fax Number

Dates Of Treatment: What dates of treatment do you need records for? You must list specific dates of service, hospitalization, treatment, etc. Date: _____

Information To Be Released

- O Anesthesia Record
- O ED Records
- O Discharge Summary
- O Laboratory
- O Nursing Notes
- O Physician Orders
- O Stress Test/Cardiology
- O Pathology
- O Pulmonary Function Test
- O Rehab/PT/OT/ST
- O X-Ray/Diagnostic Imaging
- O Physician Practice Records
- O EKG
- O Consultation(s)
- O History & Physical
- O Operative Report
- O Entire Medical Record for specific date(s) of service
- O Other, please be specific:

_____

_____

Information to be released from PHYSICIAN PRACTICES

- O Entire Practice Record for specific date(s) of service listed
- O Other, please be specific or list to left:

_____

Sensitive Information

- O Drug and Alcohol Treatment Records
- O Mental Health Records
- O Psychotherapy Notes
- O HIV/AIDS Testing and/or Treatment Records

Reason For Disclosure/Purpose

- O Attorney Request
- O Billing Purposes
- O Continuation of Care
- O Deposition
- O Disability Claim
- O Insurance Claim
- O Social Security Request
- O Worker's Compensation Claim
- O Other (please specify below):

_____

REVOCATION: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department or send by certified mail to the address above. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I have questions about the disclosure of health information, I can contact Health Information Management Department by calling (603) 444-9536.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure by the receiving party. I understand that, once disclosed to the receiving party, this information may no longer be protected by federal confidentiality rules.

MARKETING: This authorization permits the use & disclosure of healthcare information for marketing purposes. O No O Yes

HOSPITAL USE ONLY: Patient will receive remuneration from a third party for the use of this healthcare information. O No O Yes

DISCUSSION/TESTIMONY/AFFIDAVITS: I authorize the following individuals to discuss with me and/or _____ and to testify or give sworn affidavits as to whatever s/he knows about my illness, injuries and treatment, as referenced on this form.

O Any and all practitioners involved in my care O Other LRH staff O Other_____

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 Littleton Regional Healthcare if I wish to change.

_____ _____ _____ _____
Signature of: O Patient O Legal Representative Date Signature of Witness Date

If signed by Legal Representative, please indicate relationship to patient: O Durable Power of Attorney for Health Care O Legal Guardian O Parent

INTERNAL USE ONLY MRN# _____