

Elliot Health System

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

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 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 or until (date) _____ or conclusion of event.

Patient/Parent/Legal Agent Signature Date Event

Identification (if other than patient)



EH042