Office Site #NH_____

Elliot Health System

One Elliot Way
Manchester, NH 03103

VISITING NURSE ASSOCIATION of Manchester & Southern New Hampshire

1070 Holt Avenue, Suite 1400
Manchester, NH 03109

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 & Drug Abuse/Treatment
☐ Lab	☐ Progress Note	_____	☐ *Sexually Transmitted Disease (STD) Diagnosis/Treatment
☐ Abstract	☐ Complete Medical Record	_____	☐ *HIV Diagnosis/Treatment
		_____	☐ *Genetic Testing

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

INFORMATION TO BE: ☐ Picked Up ☐ Electronic – CD
☐ Mailed ☐ Electronic – Flash Drive
☐ 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. (Fees - patient's requesting copies for personal use will be provided pages 1-10 free of charge, pages 11+ will be charged a flat rate fee of $6.50. CD & Flash Drive requests arc processed for a flat rate fee of $6.50. MyEChart requests are processed for free. All other requesters will be billed at the state fee schedule allowance)

PURPOSE for which this information is being released: (check one)

☐ Continued Medical Care	☐ Legal	☐ Permanent Transfer to Another Provider
☐ Insurance	☐ Personal	☐ Consultation with Specialist
☐ Inspect records on site	☐ Other	

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 may be subject to re-disclosure and may no longer be protected by federal and state confidentiality laws. I may revoke this authorization at any time in writing, provided the information has not already been disclosed in reliance on this authorization. Additional details may be found in the Elliot Health System Notice of Privacy Practices.

I know that this authorization is voluntary, and I may refuse to sign this form. I understand that refusing to sign this form will not affect my ability to obtain treatment from Elliot Health System, the payment for my treatment, or my enrollment or eligibility for benefits unless allowed by 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 one year from the date of signature or until (date) _____ .

_____

Patient/Parent/Legal Agent Signature Date Event

_____

Identification (if other than patient)

Elliot Health System
One Elliot Way
Manchester, NH 03103

VNA Visiting Nurse Association of Manchester & Southern New Hampshire

INSTRUCTIONS

How to fill out "Release of Healthcare" Information form

PATIENT IDENTIFICATION

Complete each box as indicated with the following information: *(use blue or black ink only)*

- Patient's name, please print clearly, both first middle and last name
- Patient's Date of Birth
- Patient's mailing address, including City, State, and Zip Code
- Telephone number where you can be reached during the day *(include area code)*

RECORDS ARE TO BE RELEASED TO RECIPIENT

- Tell the individual or business entity (Company's) name
- Mailing address of who will receive the information, including City, State, and Zip Code

RECORDS ARE TO BE RELEASED FROM

- Please tell us the department name(s), Provider name(s) that you would like the records released from.

DATES OF SERVICE TO RELEASE

- Please note the date range in the FROM and TO section and use complete dates month, day and year.

PURPOSE

- The purpose the records are being requested for.

INFORMATION TO BE RELEASED

Select the boxes that apply to your request and note the requirements below for sensitive information.

- **Sensitive Health Information** - If you do not initial **and** chack the box next to the identified sensitive information and your records contain sensitive information, your medical records will not be released and an updated release will be required to process records.

DELIVERY METHOD & FEES PATIENT AND 3RD PARTY REQUESTERS

- Picked up - HIM Department - pages 1-10 are free, pages 11+ will be charged a flat rate fee of $6.50.
- Mailed USPS - pages 1-10 are free, pages 11+ will be charged a flat rate fee of $6.50.
- CD or Flash Drive - flat rate fee of $6.50.
- Electronic delivery to MyEChart - processes free of charge.
- 3rd Party requesters will be billed at the state fee schedule allowance.

DURATION & REVOCATION NOTICE

- Your authorization will remain valid for ONE YEAR from the date of your signature, unless you specify a different date on the space provided.
- You have the right to revoke your permission at any time. Please revoke by contacting the Medical Records Department in writing at One Elliot Way, Manchester NH or via fax at 603-663-1856.

SIGNATURE

- Sign and date the authorization. Patients between the ages of 12-17 may be required to sign this form, depending on the type of care received. If you are not the patient, describe your relationship and legal authority to sign. You will be required to provide legal paperwork verifying your authority (e.g. court appointed guardian, power of attorney for health care.) For a deceased patient, a court order appointing you as the executor or administrator must accompany the form.
- Should you authorization not be completed in full of not able to be processed for any reason a letter will be sent to you describing what is required to process.