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 Abuse/Treatment	
☐ Lab	☐ Progress Note	_____	☐ *Drug Abuse/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.

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 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.

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 one year from the date of signature or until (date) _____.

Patient/Parent/Legal Agent Signature Date Event

Identification (if other than patient)

EH042