

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

- |   |   |
|---|---|
| <input type="checkbox"/> History & Physical   | <input type="checkbox"/> Pathology Report         |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Consultation: Physician  |
| <input type="checkbox"/> Laboratory           | <input type="checkbox"/> Physician Notes          |
| <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Nurse's Notes            |
| <input type="checkbox"/> Emergency Department | <input type="checkbox"/> EKG/Stress/Cardiology    |
| <input type="checkbox"/> Face Sheet           | <input type="checkbox"/> Operative Report         |
| <input type="checkbox"/> Anesthesia Record    | <input type="checkbox"/> Physical Therapy Notes   |
| <input type="checkbox"/> Physician's Orders   | <input type="checkbox"/> Pulmonary Function Tests |

**SENSITIVE INFORMATION:**

- Drug and/or Alcohol Treatment Records\*\*  
 Mental Health Treatment Records  
 HIV/AIDS  
 Other: (Please Specify)

4. 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.

5. 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: \_\_\_\_\_

6. 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.

7. 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.

8. 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.

9. 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