Huggins Hospital
a member of GraniteOne Health

[PATIENT LABEL]

Request For Medical Records

(This form must be completed in full before signing)

Patient Name_____ DOB_____ Phone _____

Address _____
Street City State ZIP

Email Address: _____

1. Dates of treatment or time period _____

2. Record Format (please check one): ☐ email ☐ mail ☐ pick-up

3. Information requested (check all applicable):

☐ Emergency Dept. Record ☐ Operative/Path Report ☐ Lab/X-ray Reports ☐ Clinic/Office Visit

☐ Other Diagnostic Testing ☐ Consultation/Evaluation ☐ After Visit Summary ☐ Medications

☐Discharge Summary ☐ History & Physical

☐Other_____

4. I hereby authorize Huggins Hospital to release my information to my personal representative named:

_____ Relationship: _____

5. I understand this request is for information available at Huggins Hospital at the time of the request and will expire one day from the date signed below.

6. I understand that my records are protected under federal privacy laws and regulations and under the General Laws of New Hampshire and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug misuse information may be subject to further protection under Federal Regulation 42 CFR Part 2. Confidentiality of Alcohol and Drug Abuse.

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Signature of Patient, Legal Guardian, or Representative **Date**