

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.

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