240 South Main Street
Wolfeboro, NH 03894
603-569-7500
www.hugginshospital.org

Huggins Hospital
a member of GraniteOne Health

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name _____ Date of Birth _____ Email address _____

Mailing Address _____ City/Town _____ State/Zip _____Phone # _____

I authorize _____ to:

☐ Send/Release information to: ☐ Receive information from:

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Email: _____

Type of information released/requested:

☐ Abstract (*includes any available documents below or check only those documents needed*):

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Emergency Dept. Visit
- ☐ Progress Notes
- ☐ Laboratory Report
- ☐ Echo/EKG Report
- ☐ Radiology Report
- ☐ Physician Office Visit
- ☐

Other health information:

- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Radiology Films/CD (CD may include final report)
- ☐ Medication Records
- ☐ **Other:**_____
- ☐ Assessments
- ☐ Nurses' Notes
- ☐ Itemized Bill
- ☐ Ambulance Reports

Dates of care to be released: _____ to: _____

I UNDERSTAND THAT:

☐ Huggins Hospital will treat me even if I decline to sign this authorization.

☐ Upon request, I can inspect or obtain a copy of the information I am authorizing to be released.

☐ Information disclosed under this authorization may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state laws.

☐ I can revoke this authorization at any time by submitting a request in writing to the Huggins Hospital Health Information Management Services. This will not apply to any previously released information.

☐ I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

☐ **The following types of information WILL NOT BE INCLUDED UNLESS indicated by you initialing below:**

Drug and/or alcohol treatment **Initials:** _____
Abuse/sexual abuse **Initials:** _____
Sexually transmitted disease **Initials:** _____
HIV (AIDS) testing/treatment **Initials:** _____
Psychiatric **Initials:** _____
Genetic testing **Initials:** _____
Reproductive Hx **Initials:** _____

This authorization expires six months from the date of signature, or on: _____

SIGN HERE_____ _____ **DATE**_____

Signature of patient of legal representative — Authority or relationship of representative

To be completed by hospital staff:

Date received: _____ Date completed: _____ Completed by: _____ #of pages ___

Delivery Method ☐ In person ☐ Mail ☐ Fax ☐ Email