Dartmouth-Hitchcock

# PERMISSION TO SHARE PATIENT HEALTH INFORMATION

## PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: (  ) _____

Address: _____

City: _____ State: _____ Zip: _____

## FACILITY

**Please check the current location of the records you want shared:**

☐ Dartmouth-Hitchcock Medical Center (Lebanon) ☐ Concord ☐ Keene ☐ Manchester ☐ Nashua ☐ Plymouth Pediatrics
☐ Other: _____

## RECIPIENT

**I authorize Dartmouth-Hitchcock to share my health information with:**

Name of Person/Entity: _____

Title (Physician, Attorney, etc.): _____ Phone Number: (  ) _____

Street Address: _____

City: _____ State: _____ Zip: _____

**Purpose of Disclosure:**

☐ Medical Care ☐ Insurance ☐ Legal ☐ Transferring to New Provider ☐ Other (specify): _____

## HEALTH INFORMATION TO BE SHARED

**Copies of my health information within the following dates:** _____ **to** _____

☐ **Abstract *OR* check only those documents needed:**

☐ Discharge Summary ☐ Emergency Department Reports ☐ Immunizations
☐ Inpatient Progress Notes ☐ Laboratory/Pathology Reports ☐ Operative Reports
☐ Outpatient Visit (Office) Notes ☐ School Physical Forms ☐ X-Ray Reports ☐ X-Ray Films
☐ Other_____ ☐ Records from a specific provider: _____

**Delivery Preference:** ☐ Pickup ☐ Mail ☐ Patient Portal ☐ Fax (for Medical Care purposes) - Fax Number: (_____)_____

## SENSITIVE HEALTH INFORMATION

**The following types of information <u>will be released UNLESS</u> you place your initials in the space provided:**

_____ Mental health treatment records
_____ Genetic testing
_____ HIV/AIDS test results
_____ Sexually Transmitted Disease (STD) treatment records
_____ Alcohol/drug abuse treatment records, including Dartmouth-Hitchcock Psychiatric Associates Addiction Treatment Program (DHMC-ATP)

## DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date). You or your Personal Representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

## ADDITIONAL INFORMATION

**I understand that:**

- A fee for the cost of processing this request may be charged.
- Dartmouth-Hitchcock will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
- Once this information is shared with the recipient you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- Dartmouth-Hitchcock may utilize a business associate/authorized agent to assist in fulfilling this request.

## SIGNATURE

_____ _____

**Signature of Patient or Personal Representative** **Date**

_____ _____

**Printed Name of Patient or Personal Representative** **Description of Personal Representative's Authority**