Dartmouth-Hitchcock

INSTRUCTIONS:
How to fill out "Permission to Share Patient Health Information" authorization form

This form should be used when you want your medical records held by Dartmouth-Hitchcock to be sent to a third party.

Please complete all sections. An incomplete authorization may result in a delay in processing your request.

PATIENT INFORMATION

Complete each box as indicated with the following information:

- Patient's name (please print clearly)
- Patient's Date of Birth
- Telephone number where you can be reached during the day
- Patient's Mailing Address, including City, State, and Zip Code

FACILITY

Please tell us the current location of the records that you want shared. **If the records you need are located in more than one D-H facility, please send a copy of the "Permission to Share Patient Health Information" form to all relevant facilities to be processed.**

Concord	Keene	Lebanon	Manchester	Nashua	Plymouth Pediatrics
Medical Release Dept.	HIM Dept.	Release of Information	Health Information Services	Health Information Services	71 Highland St.
253 Pleasant St.	590 Court St.	1 Medical Center Dr.	100 Hitchcock Way	2300 Southwood Dr.	Plymouth, NH 03264
Concord, NH 03301	Keene, NH 03431	Lebanon, NH 03756	Manchester, NH 03104	Nashua, NH 03063	Ph: (603) 536-3700
Ph: (603) 229-5145	Ph: (603) 354-5477	Ph: (603) 650-7110	Ph: (603) 695-2820	Ph: (603) 577-4037	Fax: (603) 536-5384
Fax: (603) 229-5146	Fax: (603) 354-5478	Fax: (603) 727-7869	Fax: (603) 695-2536	Fax: (603) 577-4039	

RECIPIENT

Tell us the individual or business entity that is to receive the information. Include:

- Recipient's Name or Business Entity's (Company's) Name
- Title of who is to receive the information. Examples: Physician, Attorney, Insurance Company, etc.
- Telephone number of the person or entity who will receive the information
- Mailing address of who will receive the information, including City, State, and Zip Code

Check the box that best describes the purpose for sharing your health information. If no box relates to your purpose, check "Other" and state the purpose for the release on the line provided. Examples: Immunizations, Benefits, Workers' Compensation, Personal, etc. **This section must be filled out in order for the form to be valid.**

HEALTH INFORMATION TO BE SHARED

Fill in the date range that applies to the health information you are requesting we share.

Check the box(es) that apply to your request:

- An Abstract is a comprehensive **summary** of your healthcare information. An Abstract is **not** a complete copy of your health (medical) record maintained by Dartmouth-Hitchcock.
- You can tell us you want your records from only a specific provider by checking the "Records from a specific provider" box and filling in the relevant provider's name.

Please indicate delivery preference. If no options are checked, typically the records will be sent via USPS.

SENSITIVE HEALTH INFORMATION

If you do not place your initials in the space provided, we **WILL** release sensitive information contained in your medical record as necessary to fulfill your request. For more information on how we share your sensitive information, please refer to our Notice of Privacy Practices, available on our website, or contact the Privacy Office where your records are located.

DURATION & REVOCATION

Your authorization will remain valid for one year from the date of your signature, unless you specify a different date in the space provided. You have the right to revoke your permission at any time. Please revoke by following the directions in our Notice of Privacy Practices, available on our website, or call the Privacy Office where your records are located.

ADDITIONAL INFORMATION

Please read. Sometimes there is a fee for sending your records. Please call for any questions around fees.

SIGNATURE

Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign this form, depending on the type of care received.

If you are not the patient, describe your relationship and legal authority to sign. In some cases, you will be required to provide legal paperwork verifying your authority (e.g., court-appointed guardian, power of attorney for health care). For a deceased patient, a court order appointing you as the executor or administrator must accompany the form.