PERMISSION TO SEND HEALTH INFORMATION TO DARTMOUTH HEALTH

Use this form when you want your records sent to Dartmouth Health from another provider/facility.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Ph: _____

Address: _____

City: _____ State: _____ Zip: _____

SENDER

I authorize:

Name of Provider/Facility: _____

_____

Address: _____ City: _____

State: _____ Zip: _____ Fax: (_____) _____

RECIPIENT:

To share (disclose) my health information with Dartmouth Health, please send my records to the following Dartmouth Health member location:

❑ **Alice Peck Day** Health Information Services 10 Alice Peck Day Drive Lebanon NH 03766 Ph: (603) 650-7110 Fax: (603) 640-1970 Email: medicalrecords@apdmh.org	❑ **Cheshire Medical Center** HIM Department 590 Court Street Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 676-4253 Email: cmcroi@cheshire-med.com	❑ **Dartmouth Hitchcock Medical Center** Health Information Services 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7406 Email: Lebanon.Release.of.Information@hitchcock.org	❑ **Hanover Psychiatry** 23 S. Main St., Suite 2B Hanover, NH 03755 Ph: (603) 277-9110 Fax: (603) 277-9154
❑ **Manchester, Nashua & Concord - DH** Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 727-7828 Email: DH-ROI@hitchcock.org	❑ **New London Hospital** Health Information Services 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051 Email: NLHMedicalRecords@NewLondonHospital.org	❑ **Newport Health Center** Release of Information 11 John Stark Highway Newport, NH 03773 Ph: (603) 865-2855 Fax: (603) 863-3585	❑ **Visiting Nurse and Hospice for VT/NH** Health Information Services 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7406 Email: Lebanon.Release.of.Information@ hitchcock.org

If mailing my information, please return requested records to the following department/section or provider:

_____

HEALTH INFORMATION TO BE SHARED

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

- ❑ Discharge Summary
- ❑ Inpatient Progress Notes
- ❑ Outpatient Visit (Office) Notes
- ❑ Other: _____
- ❑ Emergency Department Reports
- ❑ Laboratory/Pathology Reports
- ❑ School Physical Forms
- ❑ Records from a Specific Provider: _____
- ❑ Immunizations
- ❑ Operative Reports
- ❑ X-Ray Reports
- ❑ X-Ray Films

For the following purpose: _____

SENSITIVITE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I understand and agree that this information will be sent to Dartmouth Health to include the location noted above UNLESS I place my initials in the applicable space below, next to the type of records:**

- _____ Mental health treatment records
- _____ Genetic testing
- _____ HIV/AIDS test results
- _____ Sexually transmitted disease (STD) treatment records
- _____ Alcohol/drug abuse treatment records

DURATION & REVOCATION

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

ADDITIONAL INFORMATION

I understand that: Dartmouth Health and _____ **[SENDER NAME]** will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. My sending healthcare provider may require fees to process my request.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

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