Dartmouth-Hitchcock

One Medical Center Drive
Lebanon, NH 03756-0001

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) BY DHMC

All sections of this form must be filled out completely or it will not be accepted.
I hereby authorize Dartmouth-Hitchcock Medical Center to use/disclose my individually identifiable health information as described below (which may include information concerning treatment for drug/alcohol abuse, mental health, HIV status, or genetic testing records, if applicable). I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, such as insurance company or health care provider the disclosed information may no longer be protected by federal and state privacy regulations.

Patient Name: ____ DOB: ________________________________
Address: ____ Phone Number: _________________________

Purpose of the use and/or disclosure: ____
____
____

Description of information to be disclosed:

☐ **Inpatient** relevant dates: ____
Unless otherwise specified disclosure includes Discharge Summary, Operative Records, Laboratory Report/Test Results, Consultation Reports and Progress Notes.
Additional/specific information needed: ____

☐ **Outpatient** relevant dates or provider name: ____
Unless otherwise specified disclosure includes Ambulatory Care Notes, Laboratory Report/Test Results and Emergency Department Report.
Additional/specific information needed: ____

☐ **Itemized Billing Records** relevant dates: ____

The health information shall be disclosed to (check only one): ☐ Hospital ☐ Physician ☐ Insurance Company

☐ Attorney ☐ Patient ☐ Friend or Family Member ☐ Other ____

____
Name Address

____
City State Zip Code

I understand that I may be charged for copies of my medical records.
I understand that this authorization will expire one year from the date of this authorization unless I otherwise specify. (Alternative date if desired): _________________________________.
I further understand that I may revoke this authorization at any time by notifying DHMC in writing at One Medical Center Drive, Lebanon, NH 03756, except to the extent it has already been relied upon.

____ ____________________ _______________
Signature of Patient or Personal Representative Phone Number Date

____ ______________________________________
Printed Name of Personal Representative Legal Authority of Personal Representative

At your request we will provide you a copy of this form.