

## INSTRUCTIONS:

### How to use “Permission to Send Health Information to Dartmouth-Hitchcock” form

*This form should be used when you want your health care provider to send your medical records to Dartmouth-Hitchcock. If you want D-H to send to your medical records to another health care provider or other third party, please use the “Permission to Share Patient Health Information” authorization form. You can find the form at: [http://www.dartmouth-hitchcock.org/medical-information/medical\\_records\\_release\\_forms.html](http://www.dartmouth-hitchcock.org/medical-information/medical_records_release_forms.html)*

**Please note that the sending health care provider’s office may have additional requirements for authorizing records to be released to Dartmouth-Hitchcock.**

#### PATIENT INFORMATION

Complete each box as indicated with the following information:

- Patient’s name (please print clearly)
- Patient’s date of birth
- Patient/Personal Representative’s phone number
- Patient’s mailing address, including City, State, and Zip Code

#### SENDER

Please fill in which health care provider you are authorizing to send your medical records to Dartmouth-Hitchcock:

- Provider’s name or Provider’s office/practice name
- Mailing address of the health care provider, including Street, City, State, and Zip Code
- Fax number of the health care provider’s office

#### RECIPIENT

Check the Dartmouth-Hitchcock location where you would like your information sent. You may check multiple locations. If you would like your records to be sent to a specific health care provider at Dartmouth-Hitchcock, please fill in the appropriate provider’s name or department/section (e.g., Pediatrics, Orthopedics, etc.).

#### HEALTH INFORMATION TO BE SHARED

Fill in the date range that applies to the health information you are requesting to be sent to Dartmouth-Hitchcock.

Check the box(es) that describe the information you are requesting to be sent to Dartmouth-Hitchcock.

- For multi-provider group practices, you can indicate you want to have records sent from only a specific provider by checking the “Records from a specific provider” box and filling in the relevant provider’s name.

Fill in a description of the purpose of the requested records. Examples: Transfer to new provider, facilitate treatment, summarize treatment, etc. **This section must be completed in order for the form to be valid.**

#### SENSITIVE HEALTH INFORMATION

Depending on the state where your health care provider practices, additional laws and/or signature requirements may apply to releases of “sensitive” categories of health information. **If you do not place your initials in the spaces provided**, the health care provider may release such sensitive information as necessary to fulfill your request.

#### 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. Note that your revocation will not apply to any previously released information. Please revoke by following the directions in the health care provider’s Notice of Privacy Practices, or call the provider’s office where your records are located.

#### ADDITIONAL INFORMATION

Please read this section on the form. Please fill in the blank space with the sending health care provider’s name.

#### SIGNATURE

Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign the form in addition to their parent/legal guardian, depending on the type of care received. This will be determined by the sending health care provider’s protocol.

If you are not the patient, describe your relationship and legal authority to sign on behalf of the patient. In some cases, you may be required to provide legal paperwork verifying your legal authority (e.g., court-appointed guardian, power of attorney for health care). Check with the sending health care provider’s office regarding these requirements.