



**AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
FOR INCOMING MEDICAL RECORDS**

I hereby authorize, Name/Provider: _____

Address: _____

City/State/Zip Code: _____

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 (**If I do not want this information sent I must initial below**)). I understand that this authorization is voluntary and I may refuse to sign this authorization. I further 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, e.g. insurance company or health care provider; the released information may no longer be protected by the federal and state privacy regulations.

Patient Name _____ DOB _____ Phone number _____

Address _____ Medical Record Number _____

Description of the purpose of the use and/or disclosure: (please check one)

Moving _____ Permanent _____ Temporary _____
Consultation _____ Changing Provider _____ Will continue with Specialty care _____
Accounting of Disclosures of my PHI _____ Second Opinion _____ Insurance Change _____
Other (please describe) _____

Information to be disclosed:

Related dates: _____ Immunizations _____
Office notes _____ Lab _____ reports _____
X-ray reports _____ Other test reports _____
Photographs or other Images _____ Complete Medical Record _____ Other _____

The health information described herein shall be released to (check one)

- | | |
|--|---|
| <input type="checkbox"/> Dartmouth-Hitchcock Concord
253 Pleasant Street
Concord, NH 03301
Voice (603) 229-5142 Fax (603) 229-5146 | <input type="checkbox"/> Dartmouth-Hitchcock Nashua
591 West Hollis Street
Nashua, NH 03062
Voice (603) 577-4037 Fax (603) 577-4039 |
| <input type="checkbox"/> Dartmouth-Hitchcock Manchester
100 Hitchcock Way
Manchester, NH 03104
Voice (603) 695-2535 Fax (603) 695-2536 | <input type="checkbox"/> Dartmouth-Hitchcock Keene
590 Court Street
Keene, NH 03431
Voice (603) 355-3945 Fax (603) 355-3999 |

In addition I authorize _____ to EXCLUDE information relating to (initial if applicable)

___ Acquired Immunodeficiency Virus (HIV) infection ___ Treatment for alcohol and/or substance abuse
___ Psychiatric care ___ Genetic Testing

I understand that this authorization is valid for 12 months after the date signed, unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying the above institution in writing. This written revocation must be signed and dated with a date that is later than the date on this authorization.

Signature of Patient or Personal Representative

Date

Printed name of Personal Representative

Legal Authority of Personal Representative

Approved: 2003

Revised 11/2009

Please forward to your former Provider