PERMISSION TO SEND HEALTH INFORMATION TO DARTMOUTH-HITCHCOCK

Use this form when you want a health care provider to send your medical records *to* D-H.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

SENDER

I authorize:

Name of Provider: _____

Street Address: _____ Fax Number: ( ) _____

City: _____ State: _____ Zip: _____

RECIPIENT

to share (disclose) my health information with Dartmouth-Hitchcock at the following location(s):

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

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
- ☐ Emergency Department Reports
- ☐ Immunizations
- ☐ Inpatient Progress Notes
- ☐ Laboratory/Pathology reports
- ☐ Operative Reports
- ☐ Outpatient Visit (Office) Notes
- ☐ School physical forms
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ Other_____
- ☐ Records from a specific provider: _____

For the following purpose: _____

SENSITIVE 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-Hitchcock at the location noted above UNLESS I place my initials in the applicable space next to the type of records:**

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

DURATION & REVOCATION

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

ADDITIONAL INFORMATION

I understand that: Dartmouth-Hitchcock 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. Your sending health care provider may require fees to process your request.

SIGNATURE

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

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

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

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.