

## INSTRUCTIONS:

### How to fill out "Permission to Share Protected Health Information" authorization form

*This form should be used when you want your medical records held by us to be sent to a third party.*

**Please complete all sections. An incomplete authorization may result in a delay in processing your request.**

#### PATIENT INFORMATION

Complete each section as indicated with the following information:

- Patient's name (please print clearly)
- Patient's Date of Birth
- Telephone number where requester can be reached during the day
- Patient's Mailing Address, including City, State, and Zip Code

#### DARTMOUTH-HITCHCOCK AFFILIATED COVERED ENTITY (D-H ACE) FACILITY

Please tell us the current location of the records that you want shared.

<b>Alice Peck Day</b> Health Information Services 10 Alice Peck Day Drive Lebanon NH 03766 Ph: (603) 308-0026 Fax: (603) 308-0809	<b>Cheshire Medical Center</b> HIM Dept. 590 Court St. Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 354-5478	<b>Concord</b> Medical Release Dept. 253 Pleasant St. Concord, NH 03301 Ph: (603) 229-5145 Fax: (603) 229-5146	<b>Dartmouth-Hitchcock Medical Center</b> Release of Information 1 Medical Center Dr. Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869	<b>Manchester</b> Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 676-4290	<b>Nashua</b> Health Information Services 2300 Southwood Dr. Nashua, NH 03063 Ph: (603) 577-4037 Fax: (603) 577-4039	<b>New London Hospital</b> Release of Information 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051
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#### RECIPIENT

Tell us the individual or business entity that is to receive the information. Include:

- Recipient's or Business Entity's (Company's) Name. If the information is for your own personal use, write "Self."
- Telephone number of the person or entity who will receive the information
- Mailing address of who will receive the information, including City, State, and Zip Code

#### PURPOSE

Check the box that best describes the purpose for sharing your health information. If no box relates to your purpose, check "Other" and state the purpose for the release on the line provided. **This section must be filled out in order for the form to be valid.**

#### INFORMATION TO BE SHARED

- Indicate whether you are authorizing verbal communications or medical records release, or both.
- Fill in the date range that applies to the health information you are requesting we share.
- Check the box(es) that apply to your request.
- You can tell us you want your records from only a specific provider by checking the "Records from a specific provider" box and filling in the relevant provider's name.

**DELIVERY:** Please indicate delivery preference. If no options are checked, typically the records will be sent via USPS.

**FORMAT:** Please indicate whether you want the records in paper format or in electronic format (PDF) on an encrypted CD.

#### 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. Please revoke by following the directions in our Notice of Privacy Practices, available on our website, or contact the Privacy Office at [PrivacyOffice@hitchcock.org](mailto:PrivacyOffice@hitchcock.org) or 1-844-754-8250.

#### ADDITIONAL INFORMATION

Please read. Sometimes there is a fee for sending your records. Please call for any questions around fees.

#### SENSITIVE HEALTH INFORMATION

**If you do not** place your initials in the space provided, we **WILL** release sensitive information contained in your medical record as necessary to fulfill your request. For more information on how we share your sensitive information, please refer to our Notice of Privacy Practices, available on our website, or contact the Privacy Office at [PrivacyOffice@hitchcock.org](mailto:PrivacyOffice@hitchcock.org) or 1-844-754-8250.

#### SIGNATURE

Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign this form, depending on the type of care received.

If you are not the patient, describe your relationship to the patient and legal authority to sign. In some cases, you will be required to provide legal paperwork verifying your authority (e.g., court-appointed guardian, power of attorney for health care, appointment from court of executorship/administrator of decedent's estate).