



PERMISSION TO SEND HEALTH INFORMATION TO DARTMOUTH HEALTH

Use this form when you want your records sent to Dartmouth Health from another provider/facility.

PATIENT INFORMATION and SENDER fields with authorization text: I authorize: Name of Provider/Facility: Address: City: State: Zip: Fax: ( )

RECIPIENT: To share (disclose) my health information with Dartmouth Health, please send my records to the following Dartmouth Health member location: Alice Peck Day, Cheshire Medical Center, Dartmouth Hitchcock Medical Center, Hanover Psychiatry, Manchester, Nashua & Concord - DH, New London Hospital, Newport Health Center, Visiting Nurse and Hospice for VT/NH

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, Inpatient Progress Notes, Outpatient Visit (Office) Notes, Other, Emergency Department Reports, Laboratory/Pathology Reports, School Physical Forms, Records from a Specific Provider, Immunizations, Operative Reports, X-Ray Reports, X-Ray Films

For the following purpose:

SENSITIVITE 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 Health to include the location noted above UNLESS I place my initials in the applicable space below, next to the type of records:

- Mental health treatment records, Genetic testing, HIV/AIDS test results, Sexually transmitted disease (STD) treatment records, Alcohol/drug abuse treatment records

DURATION & REVOCATION

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

ADDITIONAL INFORMATION

I understand that: Dartmouth Health 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. My sending healthcare provider may require fees to process my request.

Signature of Patient or Personal Representative, Date, Printed Name of Patient or Personal Representative, Description of Personal Representative's Authority