Dartmouth Health

Dartmouth Health Affiliated Covered Entity
Permission to Share Protected Health Information

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____ Phone: ( ) _____

Street Address: _____

City: _____ State: _____ Zip: _____

FACILITY:

Please check the current location of the records you want shared:

☐ Alice Peck Day ☐ Cheshire Medical Center ☐ DHMC-Lebanon ☐ DH-Manchester, Nashua & Concord ☐ Hanover Psychiatry

☐ New London Hospital ☐ Visiting Nurse and Hospice for VT/NH ☐ Other: _____

RECIPIENT: I authorize the entities listed above to release my information to:

Name of Person or Entity: _____ Phone Number: ( ) _____

Street Address: _____

City: _____ State: _____ Zip: _____

PURPOSE:

☐ Medical care ☐ Payment of health insurance claim ☐ Workers' Comp ☐ Legal ☐ Personal ☐ Disability determination

☐ Life insurance application ☐ Transfer of Care ☐ Other (please specify):_____

INFORMATION TO BE SHARED:

☐ VERBAL COMMUNICATION

☐ MEDICAL RECORDS

The records to be released will cover the time period from _____to_____

☐ Records from a specific provider: _____

☐ Discharge Summary	☐ Emergency Dept. Notes	☐ School/Camp Form	☐ Other: _____
☐ Inpatient Notes	☐ Lab/Path Reports	☐ Radiology Reports	_____
☐ Office or Clinic Notes	☐ Operative Reports	☐ Radiology Images	_____
☐ Billing	☐ Immunizations	☐ Photos	

Delivery: ☐ Patient Portal (myD-H) (*FREE!*) ☐ Pickup ☐ Mail to Recipient ☐ Fax Number: (_____)_____

Format: ☐ Paper ☐ CD

DURATION & REVOCATION:

My authorization is valid for one year from the date of my signature below, unless I specify a different date here: _____.
My Personal Representative or I may revoke this authorization at any time by providing written notice as specified in the D-H ACE Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

I understand that:

- A fee for the cost of processing this request may be charged.
- DH ACE members will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
- Once this information is shared with the recipient I specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- DH ACE members may utilize a business associate/authorized agent to assist in fulfilling this request.

SENSITIVE HEALTH INFORMATION This form authorizes D-H ACE members to release the following types of information, **UNLESS** you place your initials in the space provided:

_____ psychiatric treatment records	_____ sexually transmitted disease (STD) treatment records
_____ genetic testing	_____ substance use disorder treatment records from a 42 CFR Part 2
_____ HIV/AIDS test results	program

_____ _____

Signature of Patient or Personal Representative — Date

_____ _____

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

"Dartmouth Health (DH)" is the corporate parent of the covered entities listed below, each of which is an individual corporate entity legally separate and distinct from Dartmouth Health. Member organizations include: Alice Peck Day Memorial Hospital, Cheshire Medical Center, Mary Hitchcock Memorial Hospital and Dartmouth Hitchcock Clinic, operating jointly as "Dartmouth Health," Mt. Ascutney Hospital and Health Center, New London Hospital, Hanover Psychiatry and Visiting Nurses and Hospice for VT and NH. The DH ACE is comprised only of DH members who are currently using a single, integrated electronic medical record system, referred to sometimes as "eDH."

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

- **Please complete all sections. An incomplete authorization may result in a delay in processing your request.**
- ***This form should be used when you want your medical records held by us to be sent to a third party.***

PATIENT INFORMATION

Complete each section as indicated with the following information: (1) Patient's name (please print clearly); (2) Patient's Date of Birth; (3) Telephone number where requester can be reached during the day; (4) Patient's Mailing Address, including City, State, and Zip Code

DARTMOUTH HEALTH COVERED ENTITY (DH ACE) FACILITY

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

❑ **Alice Peck Day** Health Information Services 10 Alice Peck Day Drive Lebanon NH 03766 Ph: (603) 308-0026 Fax: (603) 640-1970 Email: medicalrecords@apdmh.org	❑ **Cheshire Medical Center** HIM Department 590 Court Street Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 676-4316 Email: cmcroi@cheshire-med.com	❑ **Dartmouth Hitchcock Medical Center** Release of Information 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869 Email: Lebanon.Release.of.Information@ hitchcock.org	❑ **Hanover Psychiatry** 23 S. Main St., Suite 2B Hanover, NH 03755 Ph: (603) 277-9110 Fax: (603) 277-9154
❑ **Manchester, Nashua & Concord - DH** Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 727-7828 Email: DH-ROI@hitchcock.org	❑ **New London Hospital** Release of Information 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051	❑ **Visiting Nurse and Hospice for VT/NH** Release of Information 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869 Email: Lebanon.Release.of.Information@ hitchcock.org	

RECIPIENT

Tell us the individual or business entity that is to receive the information. Include: (1) Recipient's or Business Entity's (Company's) Name. If the information is for your own personal use, write "Self;" (2) Telephone number of the person or entity who will receive the information; (3) 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 or 1-844-754-8250.

ADDITIONAL INFORMATION / QUESTIONS

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 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).