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	SENDER
Patient Name: _____	**I authorize:**
Date of Birth: _____ Ph: _____	Name of Provider/Facility: _____
Address: _____	_____
City: _____ State: _____ Zip: _____	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 (check the correct Dartmouth Health location below):

- ❑ **Alice Peck Day**, *HIS Dept., 10 Alice Peck Day Drive, Lebanon, NH 03766, Ph: 603-650-7110, Fax: 603-640-1970, email: medicalrecord@apdmh.org*
- ❑ **Cheshire Medical Center**, *HIM Dept., 590 Court Street, Keene, NH 03431, Ph: 603-354-5477, Fax: 603-676-4253 email: cmcroi@cheshire-med.com*
- ❑ **Dartmouth Health Home Care**, HIS Dept., 1 Medical Center Drive, Lebanon, NH 03756, Ph: 603-650-7110, Fax: 603-727-7406
- ❑ **Dartmouth Hitchcock Medical Center**, *HIS Dept., 1 Medical Center Drive, Lebanon NH 03756, Ph: 603-650-7110, Fax: 603-727-7406 email: DHMC.MedicalRecords@hitchcock.org*
- ❑ **Hampstead Hospital**, *HIM Dept., 218 East Road, Hampstead, NH 03841, Ph: 603-329-5311, Fax: 603-329-9460*
- ❑ **Hanover Psychiatry**, *23 S. Main Street, Suite 2B, Hanover, NH 03755, Ph: 603-277-9110, Fax: 603-277-9154*
- ❑ **Dartmouth Hitchcock Manchester, Nashua & Concord**, *HIS Dept., 100 Hitchcock Way, Manchester, NH 03104, Ph: 603-695-2820, Fax: 603-727-7828 email: DH-ROI@hitchcock.org*
- ❑ **Mt. Ascutney Hospital and Health Center**, *HIM Dept., 289 County Road, Windsor, VT 05089, Ph: 802-674-6711, Fax: 603-727-7904 email: HIM@mahhc.org*
- ❑ **New London Hospital**, *HIS Dept., 273 County Road, New London, NH 03257, Ph: 603-526-5247, Fax: 603-526-5051 email: NLHMedicalRecords@NewLondonHospital.org*
- ❑ **Newport Health Center**, *ROI Dept., 11 John Stark Highway, Newport, NH 03773, Ph: 603-865-2855, Fax: 603-863-3585*
- ❑ **Valley Regional Hospital,** *HIS Dept, 253 Elm Street, Claremont NH 03743, Ph: 603-542-1831, Fax: 603-542-1815, email*: healthinfo@vrh.org

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