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:

❑ **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) 354-547 Fax: (603) 676-4253 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	❑ **Newport Health Center** Release of Information 11 John Stark Highway Newport, NH 03773 Ph: (603) 865-2855 Fax: (603) 863-3585	❑ **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

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

INSTRUCTIONS:
How to use the "Permission to Send Health Information to Dartmouth Health" form.

This form should be used when you want your healthcare provider to send your medical records to Dartmouth Health. If you want Dartmouth Health to send your medical records to another healthcare provider or other third party, please use the "Permission to Share Patient Health Information" authorization form. You can find the form at: https://www.dartmouth-hitchcock.org/patients-visitors/medical-records-release-forms.

Please note that sending a healthcare provider's office notes may have additional requirements for authorizing records to be released to Dartmouth Health.

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 healthcare provider/facility you are authorizing to send your medical records to Dartmouth-Hitchcock including:

- Provider/facility name
- Mailing address including Street, City, State, and Zip Code
- Fax number for the healthcare provider/facility

RECIPIENT

Check the Dartmouth Health 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 healthcare provider at Dartmouth Health, please fill in the appropriate provider's name or department/section (e.g., Pediatrics, Orthopaedics, 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 Health.

Check the box(es) that describe the information you are requesting to be sent to Dartmouth Health.

- 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare provider's office regarding these requirements.

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