Dear Patient,

Thank you for choosing the New London Medical Group for your medical needs. Our goal is to provide you with quality care every time.

To ensure that the New London Medical Group team has all of your medical information, we ask that you complete and sign the attached Authorization for Release of Medical Records so we may request your records from your previous medical provider. Please note that if you do not fill in the entire Medical Record release form it will hold up the request of your records and delay your first appointment. Your records may take up to 30 days to receive; you will be contacted once your records have been processed.

Also, please complete the Patient Information and Patient History forms. You may return all forms by mail or drop them off at the main reception desk.

If you have a provider preference, please select: ☐ Male  ☐ Female

Your provider preference will be taken into consideration by the Medical Group Leadership who reviews the new patient requests.

If you have any questions, please contact us at 603-526-5544. The New London Medical Group team looks forward to taking care of your healthcare needs.

New London Hospital
Medical Group
273 County Rd, New London, NH 03257
PATIENT INFORMATION

Name: _______________________________ _______________________________ MI _______________________________

Phone: _______________________________ _______________________________ _______________________________

Mailing Address: _______________________________

Street Address: _______________________________

Sex: □ M □ F DOB: _____/_____/_____ SSN: _______________________________

Marital Status: □ M □ S □ D □ W □ Sep

Employed: □ FT □ PT □ Self □ Ret □ Military □ Not employed

Employer: _______________________________ Student: □ FT □ PT

Spouse’s Name: _______________________________ Spouse’s Phone: _______________________________

Emergency Contact (other than spouse): _______________________________

Phone: _______________________________ Relationship: _______________________________

PEDIATRIC DEMOGRAPHICS

1st Legal Parent/Guardian: _______________________________ Relationship: _______________________________

Physical Address: _______________________________ (If different from above) Street, City, St, Zip

Home Phone: _______________________________ Cell Phone: _______________________________ Work Phone: _______________________________

2nd Legal Parent/Guardian: _______________________________ Relationship: _______________________________

Physical Address: _______________________________ (If different from above) Street, City, St, Zip

Home Phone: _______________________________ Cell Phone: _______________________________ Work Phone: _______________________________

Note: (custody arrangements, adoption, language or communication barriers, etc.) _______________________________

__________________________________________

Please bring foster/adoption documentation to your first visit if applicable.
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

Patient Name: ____________________________
Date of Birth: ____________________________ Ph: ____________________________
Address: ________________________
City: __________________ State: ________ Zip: ________

Address: ________________________
City: __________________ State: ________ Zip: ________

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) 580-8026
  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: cmrc@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

- 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
  100 Hitchcock Way
  Lebanon NH 03766
  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: ____________________________

For the following purpose:

SENSITIVE 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
________ Sexually transmitted disease (STD) treatment records
________ Genetic testing
________ Alcohol/drug abuse treatment records
________ HIV/AIDS test results

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 ____________________________

Health Information Services: 8/18/2022
EFMC: 9/8/2022
Do Not Scan to eD-H Medical Record
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.

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.
Name: ____________________________________________________________________  Date: ____________________________
Age: ____________________  Birthdate: ________________  Date of Last Physical Exam: ____________________________

What is the Reason for Today’s Visit? ________________________________________________________________________________

### SYMPTOMS: CHECK (X) BOX FOR SYMPTOMS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST YEAR

<table>
<thead>
<tr>
<th>GENERAL</th>
<th>GENITAL/URINARY</th>
<th>WOMEN ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chills</td>
<td>Blood in Urine</td>
<td>Abnormal Pap Smear</td>
</tr>
<tr>
<td>Depression</td>
<td>Frequent Urination</td>
<td>Bleeding Between Periods</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Lack of Bladder Control</td>
<td>Breast Lump</td>
</tr>
<tr>
<td>Fainting</td>
<td>Painful Urination</td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td></td>
<td>Extreme Menstrual Pain</td>
</tr>
<tr>
<td>Forgetfulness</td>
<td>Bleeding Gums</td>
<td>Hot Flashes</td>
</tr>
<tr>
<td>Headache</td>
<td>Blurred Vision</td>
<td></td>
</tr>
<tr>
<td>Loss of Sleep</td>
<td>Crossed Eyes</td>
<td>Vaginal Discharge</td>
</tr>
<tr>
<td>Loss of Weight</td>
<td>Difficulty Swallowing</td>
<td>Date of Last Period:</td>
</tr>
<tr>
<td>Weight Gain</td>
<td>Double Vision</td>
<td>Date of Last Pap Smear:</td>
</tr>
<tr>
<td>Nervousness</td>
<td>Earache</td>
<td>Date of Last Mammogram:</td>
</tr>
<tr>
<td>Numbness</td>
<td>Ear Discharge</td>
<td>Number of Children:</td>
</tr>
<tr>
<td>Sweats</td>
<td>Hay Fever</td>
<td>Are You Pregnant?</td>
</tr>
</tbody>
</table>

**GASTROINTESTINAL**

<table>
<thead>
<tr>
<th>MEN ONLY</th>
</tr>
</thead>
</table>

**SKIN**

<p>| | |</p>
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<th></th>
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</table>

**CARDIOVASCULAR**

<p>| | |</p>
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<th></th>
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</table>

**MUSCLE/JOINT/BONE**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

**ALLERGIES: Medications/Substances**

**MEDICATIONS YOU CURRENTLY TAKE**

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Name #</td>
</tr>
</tbody>
</table>

### HEALTH HABITS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</table>

### OCCUPATIONAL CONCERNS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
</table>

### SERIOUS ILLNESS/INJURY

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

How often do you use these Substances:  
- Alcohol:  
- Tobacco:  
- Caffeine:  
- Drugs:  
- Other:  

Check if your work exposes you to:  
- Stress:  
- Hazardous Substances:  
- Heavy Lifting:  
- Other:  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
## HEALTH HISTORY (cont’d)

### CONDITIONS: CHECK (X) BOX FOR CONDITIONS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST YEAR

<table>
<thead>
<tr>
<th>Condition</th>
<th></th>
<th>Condition</th>
<th></th>
<th>Condition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td></td>
<td>Glaucoma</td>
<td></td>
<td>Pacemaker</td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td></td>
<td>Goiter</td>
<td></td>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td>Gout</td>
<td></td>
<td>Polio</td>
<td></td>
</tr>
<tr>
<td>Anorexia</td>
<td></td>
<td>Gonorrhea</td>
<td></td>
<td>Prostate Problems</td>
<td></td>
</tr>
<tr>
<td>Appendicitis</td>
<td></td>
<td>Heart Disease</td>
<td></td>
<td>Psychiatric Care</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td>Hepatitis</td>
<td></td>
<td>Rheumatic Fever</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Hernia</td>
<td></td>
<td>Scarlet Fever</td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorders</td>
<td></td>
<td>Herpes</td>
<td></td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Breast Lump</td>
<td></td>
<td>High Cholesterol</td>
<td></td>
<td>Suicide Attempt</td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td>HIV Positive</td>
<td></td>
<td>Thyroid Problems</td>
<td></td>
</tr>
<tr>
<td>Bulimia</td>
<td></td>
<td>Kidney Disease</td>
<td></td>
<td>Tonsillitis</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>Liver Disease</td>
<td></td>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Cataracts</td>
<td></td>
<td>Measles</td>
<td></td>
<td>Typhoid Fever</td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td></td>
<td>Migraine Headaches</td>
<td></td>
<td>Ulcers</td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td>Migraine Headaches</td>
<td></td>
<td>Ulcers</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Migraine Headaches</td>
<td></td>
<td>Ulcers</td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td></td>
<td>Multiple Sclerosis</td>
<td></td>
<td>Ulcers</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td>Mumps</td>
<td></td>
<td>Ulcers</td>
<td></td>
</tr>
</tbody>
</table>

Check (X) If your blood relatives had any of the following:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Age</th>
<th>State of Health</th>
<th>Age at Death</th>
<th>Cause of Death</th>
<th>Disease</th>
<th>Relationship to You</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td>Arthritis, Gout</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>Asthma, Hay Fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers:</td>
<td></td>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Chemical</td>
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<td></td>
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<td>Dependency</td>
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<td></td>
<td></td>
<td>Diabetes</td>
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<td></td>
<td></td>
<td>Heart Disease,</td>
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<tr>
<td></td>
<td></td>
<td>Strokes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sisters:</td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Kidney Disease</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Other</td>
<td></td>
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</tr>
</tbody>
</table>

### FAMILY HISTORY

### HOSPITALIZATIONS

<table>
<thead>
<tr>
<th>Year</th>
<th>Name of Hospital</th>
<th>Reason &amp; Outcome</th>
<th>Year of Birth</th>
<th>Gender</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Have you ever had a Blood Transfusion? □ Yes □ No If Yes, Approximate Date(s) ?

Rev Date: 8/28/2018
I hereby designate the following Personal Representative to assist me in exercising my health information rights under the New Hampshire Patients’ Bill of Rights and the federal HIPAA Privacy Rule, as indicated below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Verbal Conversations:**

I permit the staff at Dartmouth Health comprised of: Dartmouth Hitchcock Medical Center (DHMC) and Dartmouth Hitchcock Clinics (DHC); Cheshire Medical Center; Alice Peck Day Memorial Hospital (APD); New London Hospital, including Newport Health Center (NLH); Hanover Psychiatry (HP), and Visiting Nurse and Hospice for VT and NH (VNH), to discuss my protected health information, in person or by telephone, with the person named above. This includes the ability to make, cancel, or reschedule appointments on my behalf and assist me in making payments or inquiring about my billing account.

**Other:**

In addition, I grant my Personal Representative the following:

- Proxy access to my “myDH” patient portal account;
- The ability to request or receive paper or electronic copies of my medical records;
- The ability to authorize the use or disclosure of my protected health information;
- If my Personal Representative is an employee of DHMC, DHC, Cheshire Medical Center or APD the ability to access my entire medical record electronically.

I understand and acknowledge that the protected health information I am authorizing Dartmouth Health: DHMC, DHC, Cheshire Medical Center, APD, NLH, HP, or VNH to share with my Personal Representative may contain drug/alcohol abuse, mental health, HIV, and/or genetic testing information.

I understand and acknowledge that this designation applies to all clinical areas of Dartmouth Health.

This authorization shall remain in effect until I send a written request to revoke to Dartmouth Health. Submitting a new form will revoke an existing form.

Signature of Patient or Legal Representative

Legal Representative’s Name (if applicable)
Patient, Family, and Visitor Code of Conduct

Our Code of Conduct is intended to maintain a safe and caring environment for all patients, staff, and family/visitors at New London Hospital

Promoting Safety and Security

- No weapons
- No illegal or dangerous items
- No alcohol
- No drugs
- No smoking, or vaping
- No photography
- No video/audio recording

Communicating and Acting in a Respectful Manner

The following are not acceptable behaviors: Discriminatory, disruptive, disrespectful, or harassing behaviors or language (oral or written) including, but not limited to:

- Offensive remarks, requests or demands about race, national origin, ethnicity, religion, sex, gender, gender identity or expression, sexual orientation, age, disability, military or immigration status
- Yelling or swearing
- Any physical or attempted assault
- Sexual or vulgar remarks or behaviors
- Disrupting another patient’s care or experience
- Refusal to follow unit or practice specific policies or guidelines set forth for the patient’s care and treatment. This includes excessive no shows and medical noncompliance
- Unwanted communication with a clinician or other staff member not related to clinical care

Code of Conduct Violations

- If you are a patient, you may be discharged and you may not be able to receive care in the future at New London Hospital

*Does not apply to emergency treatment under EMTALA*

- If you are a family member or visitor you will be asked to leave the premises and future visitation may be restricted.

If you are a patient or family member/visitor and are the target of any of these behaviors, please report your concerns to a staff member.