Cheshire Medical Center
Dartmouth-Hitchcock Keene

PERMISSION TO SHARE PATIENT HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: ( )

Address: _____

City: _____ State: Zip:

FACILITY

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

☐ Cheshire Medical Center (inpatient) ☐ **DH** Keene **(outpatient)** _____

RECIPIENT

I authorize CMC/DHK to share my health information with:

Name of Person/Entity: _____

Title (Physician, Attorney, etc.): _____ Phone Number: ( )

Street Address: _____

City: _____ State: Zip:

Purpose of Disclosure:

☐ Medical Care ☐ Insurance ☐ Legal ☐ Transferring to New Provider ☐ Other (specify): _____

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ **to** _____

☐ **Abstract** ***OR*** ***check only those documents needed:***

☐ Discharge Summary ☐ Emergency Department Reports ☐ Immunizations

☐ Inpatient Progress Notes ☐ Laboratory/Pathology Reports ☐ Operative Reports

☐ Outpatient Visit (Office) Notes ☐ School Physical Forms ☐ X-Ray Reports ☐ X-Ray Films

☐ Other_____ ☐ Records from a specific provider: _____

Delivery Preference: ☐ Pickup ☐ Mail ☐ Patient Portal ☐ Fax (for Medical Care purposes) - Fax Number: (_____)_____

SENSITIVE HEALTH INFORMATION

The following types of information <u>will be released UNLESS</u> you place your initials in the space provided:

_____ Mental health treatment records

_____ Genetic testing

_____ HIV/AIDS test results

_____ Sexually Transmitted Disease (STD) treatment records

_____ Alcohol/drug abuse treatment records, including Dartmouth-Hitchcock Psychiatric Associates Addiction Treatment Program (DHMC-ATP)

DURATION & REVOCATION

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

ADDITIONAL INFORMATION

I understand that:

- A fee for the cost of processing this request may be charged.
- CMC/DHK 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 you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- Dartmouth-Hitchcock may utilize a business associate/authorized agent to assist in fulfilling this request.

SIGNATURE

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

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

Cheshire Medical Center
Dartmouth-Hitchcock Keene

INSTRUCTIONS:
How to fill out "Permission to Share Patient Health Information" authorization form

This form should be used when you want your medical records held by Dartmouth-Hitchcock to be sent to a third party.

Please complete all sections. An incomplete authorization may result in a delay in processing your request.

PATIENT INFORMATION

Complete each box as indicated with the following information:

- Patient's name (please print clearly)
- Patient's Date of Birth
- Telephone number where you can be reached during the day
- Patient's Mailing Address, including City, State, and Zip Code

FACILITY

Please tell us the current location of the records that you want shared. **If the records you need are located in more than one D-H facility, please send a copy of the "Permission to Share Patient Health Information" form to all relevant facilities to be processed.**

Concord	**Keene**	**Lebanon**	**Manchester**	**Nashua**	**Plymouth Pediatrics**
Medical Release Dept. 253 Pleasant St. Concord, NH 03301 Ph: (603) 229-5145 Fax: (603) 229-5146	HIM Dept. 590 Court St. Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 354-5478	Release of Information 1 Medical Center Dr. Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 650-6332	Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 695-2536	Health Information Services 2300 Southwood Dr. Nashua, NH 03063 Ph: (603) 577-4037 Fax: (603) 577-4039	71 Highland St. Plymouth, NH 03264 Ph: (603) 536-3700 Fax: (603) 536-5384

RECIPIENT

Tell us the individual or business entity that is to receive the information. Include:

- Recipient's Name or Business Entity's (Company's) Name
- Title of who is to receive the information. Examples: Physician, Attorney, Insurance Company, etc.
- Telephone number of the person or entity who will receive the information
- Mailing address of who will receive the information, including City, State, and Zip Code

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. Examples: Immunizations, Benefits, Workers' Compensation, Personal, etc. **This section must be filled out in order for the form to be valid.**

HEALTH INFORMATION TO BE SHARED

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:

- An Abstract is a comprehensive **summary** of your healthcare information. An Abstract is **not** a complete copy of your health (medical) record maintained by Dartmouth-Hitchcock.
- 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.

Please indicate delivery preference. If no options are checked, typically the records will be sent via USPS.

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 where your records are located.

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 call the Privacy Office where your records are located.

ADDITIONAL INFORMATION

Please read. Sometimes there is a fee for sending your records. Please call for any questions around fees.

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 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). For a deceased patient, a court order appointing you as the executor or administrator must accompany the form.