DARTMOUTH-HITCHCOCK MEDICAL CENTER
One Medical Center Drive
Lebanon, New Hampshire 03756

MRN:

NAME:

Authorization for Use/Disclosure of

D.O.B.

Protected Health Information (PHI) by DHMC

S.S. #:

All sections of this form must be filled out completely or it will not be accepted.

I hereby authorize Dartmouth-Hitchcock Medical Center to use/disclose my individually identifiable health information as described below (which may include information concerning treatment for drug/alcohol abuse, mental health; HIV status; or genetic testing records, if applicable). I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider; the disclosed information may no longer be protected by federal and state privacy regulations.

Purpose of the use and/or disclosure: _____

_____

_____

Description of information to be disclosed:

☐ **In-patient** Relevant Dates: _____
Unless otherwise specified disclosure includes Discharge Summary, Operative Records, Laboratory Report/Test Results, Consultation Reports, and Progress Note.

Additional/Specific Information needed: _____

☐ **Out-patient** Relevant Dates or Provider Name: _____
Unless otherwise specified disclosure includes Ambulatory Care Notes, Laboratory Report/Test Results, and Emergency Department Report.

Additional/Specific Information needed: _____

The health information shall be disclosed to (Check only one): ☐Hospital; ☐Physician; ☐Insurance Company; ☐Attorney; ☐Patient; ☐Friend or Family member; ☐Other _____

_____
Name Address

_____
City State Zip Code

I understand that this authorization will expire one year from the date of this authorization unless I otherwise specify. (Alternative date if desired): _____.
I further understand that I may revoke this authorization at any time by notifying DHMC in writing at One Medical Center Drive, Lebanon, NH 03756, except to the extent it has already been relied upon.

_____ _____ _____
Signature of Patient or Personal Representative Phone Number Date

_____ _____
Printed name of Personal Representative Legal Authority of Personal Representative

At your request we will provide you a copy of this form.

Original to Medical Record
Medical Record Approval:
11/08/03