//// Dartmouth-Hitchcock Health

Dartmouth-Hitchcock Affiliated Covered Entity Permission to Share Protected Health Information

from Dartmouth-Hitchcock Health. Member organizations include: Alice Peck Day Memorial Hospital, Cheshire Medical Center, Mary Hitchcock Memorial Hospital and D-H Clinic, operating jointly as "Dartmouth-Hitchcock," Mt. Ascutney Hospital and Health Center, New London Hospital, and the Visiting Nurses and Hospice for VT and NH. The D	PATIENT INFORMATION:							
Street Address: City: State: Zip: Zip: Zip: Zip: Zip: Zip: Zip: Zip	Patient Name:							
City: State:	Date of Birth:							
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RECIPIENT: Lathorize the entities listed above to release my information to: Name of Person or Entity: Spaulding Academy & Family Services Phone Number: (603.) 286-8901 Street Address: Z Spaulding Rd.	Alice Peck Day Cheshire	Medical Center DH-Concord	DHMC-Lebanon DH-Manchester DH-Nashua					
Name of Porson or Finity: Spaulding Academy & Family Services Phone Number: (603.) 286-8901 Street Address: 72 Spaulding Rd. City: Northfield State: NH Zje. 03276 PURPOSE Official care: Payment of health insurance claim Workers' Comp. legal Personal Disability determination Windkai care: Payment of health insurance claim Workers' Comp. legal Personal Disability determination Windkai com/UnitCa Info Transfer of Care Other (please specify): Infoat infoCONS INFORMATION TO BE STARLED Workers' Comp. legal Personal Other: Infoat infoCONS INFORMATION TO BE STARLED Emergency Dept. Notes School/Camp Form Other: Infoat i	Other:							
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Medical care Payment of health insurance clam Other (please specify): INFORMATION TO BE SHARED: INFORMATION TO BE SHARED: MEDICAL RECORD: Delivery: Palot Portal (myD-H) (FREF) My authorization is valid for one year from the date of my signature below. unless I specify a different date here: MY Parsonal Representative or I may records this authorization at any time by providing written notice as specified in the D-H ACE Notice of Privacy Practices: however, my revocation will not apply to any previously released information. I understated that:		Northfield	State: NH Zip: 03276					
Life insurance application		of health insurance claim 🔲 Wor	kers' Comp 🔲 Legal 🔲 Personal 🔲 Disability determination					
MY VERBAL COMMUNICATION MEDICAL RECORDS MEDICA	5							
MEDICAL RECORDS The records to be released will cover the time period from		RED:						
Discharge Summary Emergency Dept. Notes School/Camp Form Other: Inpatient Notes Operative Reports Radiology Reports Radiology Images Delivery: Patient Portal (myD-H) (<i>FREE</i>) Pickup Mail to Recipient Fax Number: 603 286-7511 DURATION & REVOCATION: My Personal Representative or I may revoke this authorization at any time by providing written notice as specified in the D-H ACE Notice of Privacy Practices: however, my revocation will not apply to any previously released information. I understand that: • A fee for the cost of processing this request may be charged. • D-H ACE members will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Is 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 I specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. • D-H ACE members may utilize a business secolate/authorized agent to assist in fulfilling this request. SENSITIVE HEALTH INFORMATION This form authorizes D-H ACE members to release the following types of information. UNLESS you place your initials in the space provided: substance use disorder treatment records from a 42 CFR Part 2 MinvAIDS test results program			nto					
Inplation Notes Deprative Reports Radiology Images Billing Operative Reports Photos Delivery: Patient Portal (myD-H) (<i>FREE</i>) Pickup Mail to Recipient Fax Number: 603 286-7511 DURATION & REVOCATION: My Personal Representative or I may revoke this authorization at any time by providing written notice as specified in the D-H ACE Notice of Privacy Practices: however, my revocation will not apply to any previously released information. I understand that: • A fee for the cost of processing this request may be charged. • D-H ACE members will not condition my ability to receive healthcare services on providing or refusing to provide this authorization is shared with the recipient I specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. • Dore this information is shared with the recipient I specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. • D-H ACE members may utilize a business associate/authorized agent to assist in fulfilling this request. SENSITIVE HEALTH INFORMATION This form authorized > D-H ACE members may utilize a business associate/authorized agent to relaxe the following types of information, UNLESS you place your initials in the space provided: • Dore this information is shared with the recipient I specified above, each of which is an individual corporate entity agent and better privacy regulations. • Dore this information is shared w	Records from a specif	ic provider:						
Billing Immunizations Photos Delivery: Patient Portal (myD-H) (<i>FREEI</i>) Pickup Mail to Recipient Fax Number: 603 286-7511 DURATION & REVOCATION: My authorization is valid for one year from the date of my signature below, unless I specify a different date here:	Inpatient Notes	Lab/Path Reports	Radiology Reports					
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Clinic, operating jointly as "Dartmouth-Hitchcock," Mt. Ascutney Hospital and Health Center, New London Hospital, and the Visiting Nurses and Hospice for VT and NH. The D								
H ACE comprises only of D-HH members who are currently using a single, integrated electronic medical record system, sometimes referred to as "eD-H."	Clinic, operating jointly as "Dartmouth-	Hitchcock," Mt. Ascutney Hospital and H	ealth Center, New London Hospital, and the Visiting Nurses and Hospice for VT and NH. The D					

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

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

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

PATIENTINFORMATION

Complete each section as indicated with the following information:

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

DARTMOUTH-HITCHCOCK AFFILIATED COVERED ENTITY (D-H ACE) FACILITY

Please tell us the current location of the records that you want shared.

Alice Peck Day	Cheshire Medical Center	Concord	Dartmouth-Hitchcock	Manchester	Nashua
Health Information Services	HIM Dept.	Medical Release Dept.	Medical Center	Health Information	Health Information Services
10 Alice Peck Day Drive	590 Court St.	253 Pleasant St.	Release of Information	Services	2300 Southwood Dr.
Lebanon NH 03766	Keene, NH 03431	Concord, NH 03301	1 Medical Center Dr.	100 Hitchcock Way	Nashua, NH 03063
Ph: (603) 448-7433	Ph: (603) 354-5477	Ph: (603) 229-5145	Lebanon, NH 03756	Manchester, NH 03104	Ph: (603) 577-4037
Fax: (603) 640-1984	Fax: (603) 354-6530	Fax: (603) 229-5146	Ph: (603) 650-7110	Ph: (603) 695-2820	Fax: (603) 577-4039
			Fax: (603) 727-7869	Fax: (603) 676-4290	

RECIPIENT

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

- Recipient's or Business Entity's (Company's) Name. If the information is for your own personal use, write "Self."
- 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

PURPOSE

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. This section must be filled out in order for the form to be valid.

INFORMATION TO BE SHARED

- Indicate whether you are authorizing verbal communications or medical records release, or both.
- 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.
- 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.

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

FORMAT: Please indicate whether you want the records in paper format or in electronic format (PDF) on an encrypted CD.

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 contact the Privacy Office at <u>PrivacyOffice@hitchcock.org</u> or 1-844-754-8250.

ADDITIONAL INFORMATION

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

SENSITIVE HEALTH INFORMATION

<u>If you do not</u> 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 at <u>PrivacyOffice@hitchcock.org</u> or 1-844-754-8250.

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 to the patient 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, appointment from court of executorship/administrator of decedent's estate).