

**AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED
HEALTH INFORMATION (PHI) BY DHMC**

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, such as insurance company or health care provider the disclosed information may no longer be protected by federal and state privacy regulations.

Patient Name: _____ DOB: _____
Address: _____ Phone Number: _____

Purpose of the use and/or disclosure: _____

Description of information to be disclosed:

- Inpatient** relevant dates: _____
Unless otherwise specified disclosure includes Discharge Summary, Operative Records, Laboratory Report/Test Results, Consultation Reports and Progress Notes.
Additional/specific information needed: _____
- Outpatient** 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: _____
- Itemized Billing Records** relevant dates: _____

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 I may be charged for copies of my medical records.
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.