Dartmouth-Hitchcock Health

Dartmouth-Hitchcock Affiliated Covered Entity

Permission to Share Protected Health Information

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____ Phone: ( ) _____

Street Address: _____

City: _____ State: _____ Zip: _____

FACILITY:

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

☐ Alice Peck Day ☐ Cheshire Medical Center ☐ DH-Concord ☐ DHMC-Lebanon ☐ DH-Manchester ☐ DH-Nashua

☐ Other: _____

RECIPIENT: I authorize the entities listed above to release my information to:

Name of Person or Entity: RECORDS DEPOSITION SERVICE, INC. Phone Number: (248) 357-3330

Street Address: PO BOX 5054

City: SOUTHFIELD State: MI Zip: 48086-5054

PURPOSE:

☐ Medical care ☐ Payment of health insurance claim ☐ Workers' Comp ■ Legal ☐ Personal ☐ Disability determination

☐ Life insurance application ☐ Transfer of Care ☐ Other (please specify): _____

INFORMATION TO BE SHARED:

☐ VERBAL COMMUNICATION

☐ MEDICAL RECORDS

The records to be released will cover the time period from _____ to _____

☐ Records from a specific provider: _____

☐ Discharge Summary	☐ Emergency Dept. Notes	☐ School/Camp Form	■ Other: PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST
☐ Inpatient Notes	☐ Lab/Path Reports	☐ Radiology Reports	
☐ Office or Clinic Notes	☐ Operative Reports	☐ Radiology Images	
☐ Billing	☐ Immunizations	☐ Photos	

Delivery: ☐ Patient Portal (myD-H) (*FREE!*) ☐ Pickup ■ Mail to Recipient ☐ Fax Number: (248) 357-3337

Format: ☐ Paper ■ CD

DURATION & REVOCATION:

My authorization is valid for one year from the date of my signature below, unless I specify a different date here: _____.
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. 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 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 authorizes D-H ACE members to release the following types of information, **UNLESS** you place your initials in the space provided:

_____ psychiatric treatment records
_____ genetic testing
_____ HIV/AIDS test results
_____ sexually transmitted disease (STD) treatment records
_____ substance use disorder treatment records from a 42 CFR Part 2 program

_____ **Signature of Patient or Personal Representative**

_____ **Date**

_____ **Printed Name of Patient or Personal Representative**

_____ **Description of Personal Representative's Authority**

"Dartmouth-Hitchcock Health (D-HH)" is the corporate parent of the covered entities listed below, each of which is an individual corporate entity legally separate and distinct 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-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."