

**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: Release immunizations  
\_\_\_\_\_  
\_\_\_\_\_

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:** Immunizations
- 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

Fax Number :

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.