Dartmouth College Health Service
7 Rope Ferry Road, Hanover, NH. 03755
ATTN: Medical Records
Medical.Records@Dartmouth.edu
603.646.9400 Fax: 603.646.9410

Authorization for Use and Disclosure

Patient Information:

Name: _____ DID: _____ Date of Birth: _____

Phone#: _____ Email: _____

Please select one of the following three options:

☐ I hereby authorize Dartmouth College Health Service to send the record of my care to:
☐ I hereby authorize Dartmouth College Health Service to request the record of my care from:
☐ I hereby authorize Dartmouth College Health Service to discuss medical treatment with:

Name: _____Phone: _____ Fax: _____

Delivery Address (Email or Mailing): _____
Internet communication isn't always secure. By requesting records to be released via email I acknowledge the risk.

Information authorized for disclosure:

I hereby authorize the release of the following Protected Health Information, via fax, email or mail, to/from the above-named person or persons as indicated above, and I understand that this information may include information concerning treatment for drug/alcohol abuse, mental health, HIV status, or genetic testing records, if applicable. **Requests to revoke this consent can be submitted in writing at any time to the above address.**

☐ All records **(Records from our Counseling department are separate and you should contact them for release)**
☐ Immunizations Records
☐ Lab results ONLY dated: _____
☐ X-ray results ONLY dated: _____
☐ Outpatient treatment dated: _____
☐ Inpatient treatment dated: _____
☐ Other: _____

Please exclude the following information: _____

Purpose of this disclosure is: _____

Read and Sign

I understand that my records are protected and maintained in accordance with applicable State and Federal laws and regulations, and that any information that is received by Dartmouth College Health Service will be held to the same standards. Once the requested information is released from Dartmouth College Health Service records it may no longer be protected by Federal and State regulations and there is a potential for it to be re-disclosed by the recipient.

You are not required to sign this authorization as a condition to the provision of service.

There is a $15 processing and copy fee for medical records released from Dartmouth College (immunizations records are free of charge). Records requested from other institutions may be subject to a fee of their determination.

This authorization will expire one year from the date signed, unless earlier revoked or alternate date is specified here: __/__/____

_____

Signature of Patient or Personal Representative **Date Signed**

_____

Printed Name of Patient or Personal Representative and Relationship to the Patient