Thank you for choosing Gynecology at Alice Peck Day Memorial Hospital for your gynecologic care. We are located at 9 Alice Peck Day Drive in Lebanon, NH. We have sent this paperwork to you to become a new patient with us, to re-establish your care with us, or because we have received a referral on your behalf from another provider.

In order to help us to see patients on time and in an efficient manner, please take a few moments to fill out the enclosed forms. Be as complete as possible.

Once this completed paperwork is received we will gladly schedule you with the first available appointment.

We look forward to your visit and hope to bring you the highest quality care possible. Thank you for doing your part to assist us in that endeavor.
### New Patient Intake - Gynecology

**Women’s Care Center**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>MR#:</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>Physical Address:</td>
<td></td>
</tr>
<tr>
<td>Home Phone:</td>
<td></td>
</tr>
<tr>
<td>Cell Phone:</td>
<td></td>
</tr>
<tr>
<td>Marital Status:</td>
<td></td>
</tr>
<tr>
<td>Race:</td>
<td></td>
</tr>
<tr>
<td>Ethnicity:</td>
<td></td>
</tr>
<tr>
<td>Social Security Number:</td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider:</td>
<td></td>
</tr>
<tr>
<td>Primary Language:</td>
<td></td>
</tr>
<tr>
<td>Employer:</td>
<td></td>
</tr>
<tr>
<td>Work Phone:</td>
<td></td>
</tr>
<tr>
<td>Preferred Pharmacy:</td>
<td></td>
</tr>
<tr>
<td>Preferred Name</td>
<td></td>
</tr>
</tbody>
</table>

### FIRST INSURANCE INFORMATION:

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder's Gender:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder's Relation to Patient:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder's Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder's SS #:</td>
<td></td>
</tr>
</tbody>
</table>

### SECOND INSURANCE INFORMATION:

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder's Gender:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder's Relation to Patient:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder's Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Policy Holder's SS #:</td>
<td></td>
</tr>
</tbody>
</table>

### PARENT/GUARDIAN or PERSON RESPONSIBLE FOR BILL (Complete only if different from patient):

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>MR#:</td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>Physical Address:</td>
<td></td>
</tr>
<tr>
<td>Home Phone:</td>
<td></td>
</tr>
<tr>
<td>Cell Phone:</td>
<td></td>
</tr>
<tr>
<td>Marital Status:</td>
<td></td>
</tr>
<tr>
<td>Race:</td>
<td></td>
</tr>
<tr>
<td>Ethnicity:</td>
<td></td>
</tr>
<tr>
<td>Social Security Number:</td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider:</td>
<td></td>
</tr>
<tr>
<td>Primary Language:</td>
<td></td>
</tr>
<tr>
<td>Employer:</td>
<td></td>
</tr>
<tr>
<td>Work Phone:</td>
<td></td>
</tr>
<tr>
<td>Preferred Pharmacy:</td>
<td></td>
</tr>
<tr>
<td>Preferred Name</td>
<td></td>
</tr>
</tbody>
</table>

---

#12817  (04/18)  AlicePeckDay.org
New Patient Intake - Gynecology
Women’s Care Center

Name: ____________________________________  Social Security Number: ____________________________
Address: ____________________________________________
Home Phone: ______________________________  Relation to Patient: _________________________________

PRIOR HEALTH CARE/ADVANCE DIRECTIVES:
Last Primary Healthcare Provider- Name & Location: _____________________________________________
Do you have a Living Will:  ☐ Yes  ☐ No
Do you have a Durable Power of Attorney for Health Care:  ☐ Yes ☐ No
If yes, who: _________________________________  Relationship: _________________________________
Phone number:------------------

(Please Print)
New Patient Intake - Gynecology
Women’s Care Center

<table>
<thead>
<tr>
<th>Name:</th>
<th>MR#:</th>
<th>place patient sticker here</th>
<th>DOB:</th>
</tr>
</thead>
</table>

Your Name (Last): __________________________ (First): ____________________ (M.I.): ______

Date of Birth: __________________________ Referred Here by: __________________________

I Attest That the Information Here Is True and Correct to The Best of My Belief.

_________________________________________ 
Patient Signature 

Date

Past Medical History

(If you have ever had any of these conditions – Please check all that apply)

**Breast Conditions:**
- [ ] Abnormal Mammogram
- [ ] Breast Cancer: [ ] Left [ ] Right
- [ ] Breast Implants
- [ ] Fibrocystic Breasts
- [ ] Other: __________________________

**Endocrine (Glandular) Disorders:**
- [ ] Diabetes – Type I (Insulin-Dependent)
- [ ] Diabetes – Type II
- [ ] Pituitary Gland Disorder
- [ ] Thyroid Disease (Hypo) or (Hyper)
- [ ] High Cholesterol
- [ ] Other: __________________________

**Gyn Problems:**
- [ ] Abnormal Pap Smear
- [ ] Cervical Cancer (Neoplasm)
- [ ] Dysmenorrhea (Painful Menses)
- [ ] Endometrial (Uterine) Cancer
- [ ] Endometriosis
- [ ] Fibroids
- [ ] Herpes
- [ ] Human Papilloma Virus Infection (HPV)
- [ ] Ovarian Cancer
- [ ] Ovarian Cysts
- [ ] Pelvic Inflammatory Disease (PID)
- [ ] Polycystic Ovarian Syndrome (PCOS)
- [ ] Sexually Transmitted Disease (STD)
- [ ] Vaginal Cancer (Neoplasm)
- [ ] Vulvar Cancer (Neoplasm)
- [ ] Other: __________________________

**Immune System Diseases:**
- [ ] Chronic Fatigue Syndrome
- [ ] Sinus Allergies
- [ ] Systemic Lupus
- [ ] Rheumatoid Arthritis
- [ ] Other: __________________________

**Gastrointestinal (GI) Problems:**
- [ ] Colitis, Ulcerative
- [ ] Crohn’s Disease
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Irritable Bowel Syndrome
- [ ] Other: __________________________

**Blood (Hematologic) Disorders:**
- [ ] Anemia
- [ ] Bleeding Disorder
- [ ] Clotting Disorder
- [ ] Sickle Cell Trait or Disease
- [ ] Thalassemia
- [ ] Other: __________________________

**Neurologic Disorders:**
- [ ] Common Migraines
- [ ] Headaches (Other)
- [ ] Multiple Sclerosis
- [ ] Seizure Disorder (Epilepsy)
- [ ] TIA or Stroke
- [ ] Other: __________________________
(If you have ever had any of these conditions – Please check all that apply - continued)

Heart or Circulation Conditions (Cardiovascular):
- Congenital Heart Disease
- Congestive Heart Failure
- Coronary Artery Disease
- CVA (Stroke)
- Hypertension (High Blood Pressure)
- Irregular Heart Beat
- Mitral Valve Disorders (MVP)
- Pulmonary Embolism (Blood Clot in Lung)
- Thrombophlebitis (Blood Clot in Extremity)
Other:

Musculoskeletal Disorders:
- Arthritis
- Joint Pain
- Fibromyalgia
- Osteopenia
- Osteoporosis
- Scoliosis
- Systemic Lupus Erythematosus
Other:

Psychiatric or Emotional Conditions:
- ADHD/ADD
- Bipolar (Manic-Depressive)
- Major Depression
- OCD (Obsessive-Compulsive)
- Postpartum Depression
- Severe Anxiety or Panic Attacks
Other:

Respiratory (Lung) or ENT Disorders:
- Asthma
- COPD
- Lung Cancer
- Pneumonia - Recurrent
- Sleep Apnea
- Tuberculosis
Other:

Skin Conditions:
- Acne (Severe)
- Eczema
- Hirsutism (Excess Hair Growth)
- MRSA
- Psoriasis
Other:

Genetic Disorders:
- Cystic Fibrosis
- Muscular Dystrophy
Other:

Past Surgical History
(Please include any D&C, D&E, Colposcopy, Cryotherapy or Colonoscopy Surgeries)

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Reason</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Herbs, Vitamins and Supplements You Are Taking

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Dose (if known)</th>
<th>How Often</th>
<th>Start Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medications You Are Taking

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dose (if known)</th>
<th>How Often</th>
<th>Start Date</th>
<th>Prescribed By</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Primary Pharmacy Name: ________________________________ Phone: ____________
Pharmacy Address: __________________________________________

**Allergies**

Do You Have Any Known Medication Allergies?  □ Yes  □ No

Are you allergic to any of the following (check all that apply):

□ Peanuts  □ Latex  □ Iodine  □ Shellfish  □ Adhesive Tape  □ Band Aids

Other: __________________________

Please list all allergies and the allergic reaction:

<table>
<thead>
<tr>
<th>Allergic To (medications, foods, environmental)</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Family Medical History

If Any close relative (Brothers, Sisters, Parents, Children, Grandparent [Maternal or Paternal], Aunt/Uncle) Has Ever Had or Currently Has any of the problems listed below, place a check and enter the relationship to you.

- **Endometriosis**: Yes ☐ No ☐ Who (be specific): __________
- **Uterine Fibroids**: Yes ☐ No ☐ Who (be specific): __________
- **Breast Cancer**: Yes ☐ No ☐ Who (be specific): __________
- **Colon Cancer**: Yes ☐ No ☐ Who (be specific): __________
- **Heart Disease**: Yes ☐ No ☐ Who (be specific): __________
- **High Blood Pressure**: Yes ☐ No ☐ Who (be specific): __________
- **High Cholesterol**: Yes ☐ No ☐ Who (be specific): __________
- **Blood Clots**: Yes ☐ No ☐ Who (be specific): __________
- **Diabetes – Type I**: Yes ☐ No ☐ Who (be specific): __________
- **Diabetes – Type II**: Yes ☐ No ☐ Who (be specific): __________
- **Hyperthyroidism**: Yes ☐ No ☐ Who (be specific): __________
- **Hypothyroidism**: Yes ☐ No ☐ Who (be specific): __________
- **Lung Cancer**: Yes ☐ No ☐ Who (be specific): __________
- **Depression**: Yes ☐ No ☐ Who (be specific): __________
- **Bipolar Disorder**: Yes ☐ No ☐ Who (be specific): __________
- **Other Malignancies (Site)**: Yes ☐ No ☐ Who (be specific): __________

Menstrual History

- **Menopause Status**: □ Premenopausal □ Postmenopausal □ Perimenopausal

  Age Menopause: ______

- **Are You Sexually Active?**: □ Yes □ No With: □ Men □ Women □ Both

  Age of First Menstrual Period: __________

  Cycle Length (28 days or?): __________

Number days of bleeding with a period: __________

  Period Flow: □ Light □ Medium □ Heavy

Date of Last Normal Menstrual Period (if abnormal describe): __________

Birth Control Method Using Now: __________

(*Period Means # Days of Bleeding; Cycle Length Means Total # of Bleeding and Non-Bleeding Days Until the Next Period Begins)
New Patient Intake - Gynecology
Women’s Care Center

Pregnancy Summary (How Many…?)

<table>
<thead>
<tr>
<th>Total # of Pregnancies</th>
<th>Full Term Births (more than 37 weeks)</th>
<th>Premature Births (less than 37 weeks)</th>
<th>Terminations</th>
<th>Miscarriages (was surgery needed?)</th>
<th>Ectopic Pregnancies (left or right?)</th>
<th>Number of Living Children</th>
</tr>
</thead>
</table>

(please provide date of terminations, miscarriages and ectopic pregnancies)

Comments: ________________________________________________________________

Pregnancy Details

<table>
<thead>
<tr>
<th>Child's Birthdate (mm/dd/yr)</th>
<th>Child's Name</th>
<th># Weeks At Delivery</th>
<th>Length of Labor</th>
<th>Birth Weight</th>
<th>M or F</th>
<th>Type of Delivery (Vaginal or C/S)</th>
<th>Anesthesia</th>
<th>Complications or Problems</th>
<th>Physician</th>
<th>Location</th>
</tr>
</thead>
</table>

Social History

Marital Status: □ Dating □ Divorced □ Engaged □ Married □ Not Dating
□ Separated □ Single □ Widowed □ Living with Significant Other

Alcohol Use: □ Never □ Current □ Former
How Much: ______________ Age Started: _______ Age Stopped: _______

Illegal Drug Use: □ Never □ Current □ Former
Which Drug(s): ____________________
How Often: ____________________ Age Started: _______ Age Stopped: _______
When Last Used: ____________________

Tobacco Use: □ Never □ Current □ Former
How Much: ______________ Age Started: _______ Age Stopped: _______

Caffeine Use: □ Yes □ No
How Much: ____________________

Exercise Habits: □ Sedentary □ Active but no formal exercise
□ Minimal Amount of Exercise (once weekly or less)
□ Moderate Amount of Exercise (1-3 times weekly)
□ Heavy Amount of Exercise (4 or more times weekly)
Type of Exercise: ____________________
Occupation: ____________________________________________________________

Hobbies: ______________________________________________________________

Check If You Currently Have Any of the Following Symptoms

**CONSTITUTIONAL:**
- [ ] Weight loss
- [ ] Weight gain
- [ ] Fatigue/Weakness
- [ ] Fever

**EYES:**
- [ ] Vision problem

**HENT:**
- [ ] Headaches

**BREAST:**
- [ ] Breast Lumps
- [ ] Breast Pain
- [ ] Breast Discharge
- [ ] Leaking Milk

**CARDIOVASCULAR:**
- [ ] Chest pain
- [ ] Short of breath on exertion
- [ ] Heart murmur
- [ ] Swelling in legs

**RESPIRATORY:**
- [ ] Wheezing
- [ ] Shortness of breath
- [ ] Spitting up blood
- [ ] Cough

**ALLERGIC-IMMUNOLOGIC:**
- [ ] Sinus allergy symptoms

**GENITOURINARY:**
- [ ] Not having periods
- [ ] Irregular periods
- [ ] Heavy periods
- [ ] Bleeding between periods
- [ ] Painful periods
- [ ] Pelvic pain
- [ ] Pain with intercourse
- [ ] Spotting with or after intercourse
- [ ] Decreased sex drive
- [ ] Vaginal discharge
- [ ] Vaginal dryness
- [ ] Hot flashes
- [ ] Urinary frequency
- [ ] Urinary urgency
- [ ] Difficulty starting to urinate
- [ ] Painful urination
- [ ] Blood in urine
- [ ] Leaking urine with cough
- [ ] Leaking urine with urge

**INTEGUMENTARY:**
- [ ] Rash
- [ ] Itching
- [ ] New skin lesions
- [ ] Changes in existing moles

**NEUROLOGIC:**
- [ ] Seizures
- [ ] Dizziness
- [ ] Syncope (Fainting/Passing out)
Check If You Currently Have Any of the Following Symptoms (continued)

GASTROINTESTINAL:
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Diarrhea
☐ Constipation
☐ Bloody stool

MUSCULOSKELETAL:
☐ Joint pain
☐ Joint swelling
☐ Muscle pain
☐ Muscular weakness

ENDOCRINE:
☐ Excessive urination
☐ Excessive thirst
☐ Cold intolerance
☐ Heat intolerance
☐ Loss of hair
☐ Changes in hair texture
☐ Changes in skin texture
☐ Excessive hair growth

PSYCHIATRIC:
☐ Anxiety
☐ Depression
☐ Difficulty sleeping

HEMATOLOGIC
☐ Anemia
☐ Easy bleeding
☐ Easy bruising
☐ Swollen lymph nodes

Well Woman Screening History

Please Indicate the Date of Your Last:

Pap: ________________________________

Mammogram: _________________________

Colonoscopy: _________________________

Lipid Screening: ______________________

Glucose Test: _________________________

Dexa (Bone) Scan: ____________________
PERMISSION TO SEND HEALTH INFORMATION TO A
DARTMOUTH-HITCHCOCK AFFILIATED COVERED ENTITY

Use this form when you want a health care provider to send your medical records to D-HH.

### PATIENT INFORMATION

Patient Name: _____________________________________________________________

Date of Birth: ___________________________ Phone Number: _______________________

Address: ____________________________________________ City: __________ State: ______ Zip: ______

### SENDER

I authorize:

Name of Provider: _____________________________________________________________

Street Address: ____________________________________________ Fax Number: ______

City: __________ State: ______ Zip: ______

### RECIPIENT

Below are the locations to share (disclose) your health information with Dartmouth-Hitchcock Health:

- Alice Peck Day Health Information Services
  - Ph: (603) 448-7433
  - Fax: (603) 640-1984
- Cheshire Medical Center
  - HIM Dept.
  - Ph: (603) 354-5477
  - Fax: (603) 354-6530
- Concord DH Medical Release Dept
  - Ph: (603) 229-5145
  - Fax: (603) 229-5146
- DHMC Release of Information
  - Ph: (603) 650-7110
  - Fax: (603) 727-7869
- Manchester DH Health Information Services
  - Ph: (603) 695-2820
  - Fax: (603) 676-4290
- Nashua DH Health Information Services
  - Ph: (603) 577-4037
  - Fax: (603) 577-4039

If mailing my information, please return requested records to the following department/section or provider:

__________________________________________________________

### HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: ____________ to ____________

- Discharge Summary
- Emergency Department Reports
- Inpatient Progress Notes
- Laboratory/Pathology reports
- Outpatient Visit (Office) Notes
- School Physical Forms
- Other: ______________________________________________________________________
- Records from a Specific Provider: ______________________________________________

For the following purpose: ______________________________________________________________________

### SENSITIVE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I understand and agree that this information will be sent to Dartmouth-Hitchcock Health to include the location noted above UNLESS I place my initials in the applicable space below, next to the type of records:**

- Mental health treatment records
- Sexually Transmitted Disease (STD) treatment records
- Genetic testing
- Alcohol/drug abuse treatment records
- HIV/AIDS test results

### DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless I specify a different date here: ____________(date). I or my Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider’s Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

### ADDITIONAL INFORMATION

**I understand that:** Dartmouth-Hitchcock Health and ______________________ [SENDER NAME] will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. My sending healthcare provider may require fees to process my request.

### SIGNATURE

__________________________

Signature of Patient or Personal Representative

__________________________

Date

__________________________

Printed Name of Patient or Personal Representative

__________________________

Description of Personal Representative’s Authority
INSTRUCTIONS:
How to use “Permission to Send Health Information to Dartmouth-Hitchcock” form

This form should be used when you want your health care provider to send your medical records to Dartmouth-Hitchcock. If you want D-H to send to your medical records to another health care provider or other third party, please use the “Permission to Share Patient Health Information” authorization form. You can find the form at: http://www.dartmouth-hitchcock.org/medical-information/medical_records_release_forms.html

Please note that the sending health care provider’s office may have additional requirements for authorizing records to be released to Dartmouth-Hitchcock.

PATIENT INFORMATION
Complete each box as indicated with the following information:
- Patient’s name (please print clearly)
- Patient’s date of birth
- Patient/Personal Representative’s phone number
- Patient’s mailing address, including City, State, and Zip Code

SENDER
Please fill in which health care provider you are authorizing to send your medical records to Dartmouth-Hitchcock:
- Provider’s name or Provider’s office/practice name
- Mailing address of the health care provider, including Street, City, State, and Zip Code
- Fax number of the health care provider’s office

RECIPIENT
Check the Dartmouth-Hitchcock Health location where you would like your information sent. You may check multiple locations. If you would like your records to be sent to a specific health care provider at Dartmouth-Hitchcock Health, please fill in the appropriate provider’s name or department/section (e.g., Pediatrics, Orthopedics, etc.).

HEALTH INFORMATION TO BE SHARED
Fill in the date range that applies to the health information you are requesting to be sent to Dartmouth-Hitchcock.

Check the box(es) that describe the information you are requesting to be sent to Dartmouth-Hitchcock.
- For multi-provider group practices, you can indicate you want to have records sent from only a specific provider by checking the “Records from a specific provider” box and filling in the relevant provider’s name.

Fill in a description of the purpose of the requested records. Examples: Transfer to new provider, facilitate treatment, summarize treatment, etc. This section must be completed in order for the form to be valid.

SENSITIVE HEALTH INFORMATION
Depending on the state where your health care provider practices, additional laws and/or signature requirements may apply to releases of “sensitive” categories of health information. If you do not place your initials in the spaces provided, the health care provider may release such sensitive information as necessary to fulfill your request.

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. Note that your revocation will not apply to any previously released information. Please revoke by following the directions in the health care provider’s Notice of Privacy Practices, or call the provider’s office where your records are located.

ADDITIONAL INFORMATION
Please read this section on the form. Please fill in the blank space with the sending health care provider’s name.

SIGNATURE
Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign the form in addition to their parent/legal guardian, depending on the type of care received. This will be determined by the sending health care provider’s protocol.

If you are not the patient, describe your relationship and legal authority to sign on behalf of the patient. In some cases, you may be required to provide legal paperwork verifying your legal authority (e.g., court-appointed guardian, power of attorney for health care). Check with the sending health care provider’s office regarding these requirements.