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>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>_______________</td>
</tr>
<tr>
<td>(last name, first name, middle initial)</td>
<td>_______________</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>_______________</td>
</tr>
<tr>
<td>Gender:</td>
<td>Male □ Female □</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>___________________________________________________________________</td>
</tr>
<tr>
<td>(street)</td>
<td>_______________</td>
</tr>
<tr>
<td>(City/State/Zip)</td>
<td>_______________</td>
</tr>
<tr>
<td>Physical Address (if different from mailing):</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>Married □ Single □ Divorced □ Widow □</td>
</tr>
<tr>
<td>Race:</td>
<td>White □ African American □ American Indian □ Asian □</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td>Hispanic/Latino □ Non-Hispanic/Non-Latino □</td>
</tr>
<tr>
<td>Social Security Number:</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 (what do you prefer we call you, if different than above):</td>
<td>____________________</td>
</tr>
</tbody>
</table>

**FIRST INSURANCE INFORMATION:**
Plan Name: ____________________
Policy Number: ____________________
Address: ___________________________________________________________________
Group Number: ____________________
Policy Holder: ____________________
Policy Holder's Date of Birth: ____________________
Policy Holder's Gender: Male □ Female □
Policy Holder's SS #: ____________________
Policy Holder's Relation to Patient: ____________________
Effective Date: ____________________

**SECOND INSURANCE INFORMATION:**
Plan Name: ____________________
Policy Number: ____________________
Address: ___________________________________________________________________
Group Number: ____________________
Policy Holder: ____________________
Policy Holder's Date of Birth: ____________________
Policy Holder's Gender: Male □ Female □
Policy Holder's SS #: ____________________
Policy Holder's Relation to Patient: ____________________
Effective Date: ____________________

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

(#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

Name: ___________________________ MR#: _______________________
DOB: ___________________________

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)

**Musculoskeletal Disorders:**
- [ ] Arthritis
- [ ] Joint Pain
- [ ] Fibromyalgia
- [ ] Osteopenia
- [ ] Osteoporosis
- [ ] Scoliosis
- [ ] Systemic Lupus Erythematosus
- [ ] 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>Product Name</td>
<td>Dose (if known)</td>
<td>How Often</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>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<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):

- [ ] Contrast Dye
- [ ] Nickel
- [ ] 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>
New Patient Intake - Gynecology
Women's Care Center

Name: 
MR#: place patient sticker here
DOB: 

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):

- Ovarian Cancer
  - Yes
  - No
  - Who (be specific):

- Uterine Cancer
  - Yes
  - No
  - Who (be specific):

- Endometrial Cancer
  - Yes
  - No
  - Who (be specific):

- Osteoporosis
  - 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>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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: __________________

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

Name: ____________________________
MR#: ____________________________
DOB: ____________________________

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: __________________
Dartmouth-Hitchcock Affiliated Covered Entity
Permission to Share Protected Health Information

PATIENT INFORMATION:

Patient Name: ___________________________
Date of Birth: ___________________________
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
☒ New London Hospital ☐ Other: ___________________________

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

Name of Person or Entity: ___________________________
Phone Number: (_________)
Street Address: ___________________________
City: __________________ State: ______ Zip: _______

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: ___________________________
☐ 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: (_________)
Format: ☒ Paper ☐ CD ☐ FREE

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 ☐ _______ sexually transmitted disease (STD) treatment records
☐ _______ genetic testing ☐ _______ substance use disorder treatment records from a 42 CFR Part 2
☐ _______ HIV/AIDS test results ☐ _______ 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.”
**INSTRUCTIONS:**

How to fill out “Permission to Share Protected Health Information” authorization form

*This form should be used when you want your medical records held by us to be sent to a third party.*

Please complete all sections. An incomplete authorization may result in a delay in processing your request.

### PATIENT INFORMATION

Complete each section as indicated with the following information:

- Patient’s name (please print clearly)
- Patient’s Date of Birth
- Telephone number where requester can be reached during the day
- Patient’s Mailing Address, including City, State, and Zip Code

### DARTMOUTH-HITCHCOCK AFFILIATED COVERED ENTITY (D-H ACE) FACILITY

Please tell us the current location of the records that you want shared.

| Alice Peck Day Health Information Services | Cheshire Medical Center | Concord | Dartmouth-Hitchcock Medical Center | Manchester Health Information Services | Nashua Health Information Services | New London Hospital
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Alice Peck Day Drive Lebanon, NH 03766</td>
<td>590 Court St. Keene, NH 03431</td>
<td>Medical Release Dept. 253 Pleasant St. Concord, NH 03301</td>
<td>1 Medical Center Dr. Lebanon, NH 03756</td>
<td>100 Hitchcock Way Manchester, NH 03104</td>
<td>2300 Southwood Dr. Nashua, NH 03063</td>
<td>Release of Information 273 County Road New London, NH 03257</td>
</tr>
<tr>
<td>Ph: (603) 448-7433 Fax: (603) 640-1984</td>
<td>Ph: (603) 354-5477</td>
<td>Ph: (603) 229-5145 Fax: (603) 229-5146</td>
<td>Ph: (603) 650-7110 Fax: (603) 727-7869</td>
<td>Ph: (603) 685-2820 Fax: (603) 676-4290</td>
<td>Ph: (603) 577-4037 Fax: (603) 577-4039</td>
<td>Fax: (603) 526-5247 Fax: (603) 526-5051</td>
</tr>
</tbody>
</table>

### RECIPIENT

Tell us the individual or business entity that is to receive the information. Include:

- Recipient’s or Business Entity’s (Company’s) Name. If the information is for your own personal use, write “Self.”
- Telephone number of the person or entity who will receive the information
- Mailing address of who will receive the information, including City, State, and Zip Code

### PURPOSE

Check the box that best describes the purpose for sharing your health information. If no box relates to your purpose, check “Other” and state the purpose for the release on the line provided. **This section must be filled out in order for the form to be valid.**

### INFORMATION TO BE SHARED

- Indicate whether you are authorizing verbal communications or medical records release, or both.
- Fill in the date range that applies to the health information you are requesting we share.
- Check the box(es) that apply to your request.
- You can tell us you want your records from only a specific provider by checking the “Records from a specific provider” box and filling in the relevant provider’s name.

### DELIVERY:

Please indicate delivery preference. If no options are checked, typically the records will be sent via USPS.

### FORMAT:

Please indicate whether you want the records in paper format or in electronic format (PDF) on an encrypted CD.

### 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. Please revoke by following the directions in our Notice of Privacy Practices, available on our website, or contact the Privacy Office at PrivacyOffice@hitchcock.org or 1-844-754-8250.

### ADDITIONAL INFORMATION

Please read. Sometimes there is a fee for sending your records. Please call for any questions around fees.

### SENSITIVE HEALTH INFORMATION

**If you do not** place your initials in the space provided, we **WILL** release sensitive information contained in your medical record as necessary to fulfill your request. For more information on how we share your sensitive information, please refer to our Notice of Privacy Practices, available on our website, or contact the Privacy Office at PrivacyOffice@hitchcock.org or 1-844-754-8250.

### SIGNATURE

Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign this form, depending on the type of care received.

If you are not the patient, describe your relationship to the patient and legal authority to sign. In some cases, you will be required to provide legal paperwork verifying your authority (e.g., court-appointed guardian, power of attorney for health care, appointment from court of executorship/administrator of decedent’s estate).