



**Dartmouth-Hitchcock
MEDICAL CENTER**

One Medical Center Drive
Lebanon, NH 03756

Request for Medical Record

MRN:

NAME:

D.O.B.

TO: Medical Record Department

FROM:

- _____
Facility or Doctor
- _____
Address
- _____ State _____ zip
City/Town

Familial Cancer Program
Requesting Section:
Bradley A. Arrick, MD, PhD
Doctor:
Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, New Hampshire 03756
Tel. (603) 653-3541
Fax (603) 653-3583

PATIENT IDENTIFICATION

DATE OF BIRTH

NAME	PREVIOUS OR MAIDEN NAME
ADDRESS	CITY-STATE-ZIP CODE

- Copy of medical record for date(s) _____
- In-patient Out-patient
- Copy of Operative Report of _____
- X-ray reports Type _____ Date(s) _____
- Other: _____

The Federal Privacy Rule permits disclosure of protected health information for purposes of treatment, payment or operation without patient authorization. §164.502(a)(1).

I understand that disclosing my individually identifiable health information as described above to Dartmouth-Hitchcock Medical Center may include information concerning treatment for drug/alcohol abuse, mental health, HIV status or genetic testing. I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Signature or Patient or Personal Representative

Date

Printed name of Personal Representative

Legal Authority of Personal Representative