New London Hospital
Dartmouth-Hitchcock

New London Medical Group/NHC Patient Authorization

Patient Name: _____ Date of Birth: _____

I give the following person (s) permission to have access to:

Please check all that applies:

- ☐ Discuss only Medical Information (No release of medical records)
- ☐ Access to my Portal both Hospital and Medical Group
- ☐ Pick up Prescriptions

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient/Guardian/Representative Date

_____
Relationship to Patient

**** Expires 1 year from date signed

Name: DOB:

Date	Script Name	Printed Name	Signature