Authorization Form

For the Disclosure of Protected/Confidential Information by NH DHHS to a Third Party

The following form is to be used by Department of Health & Human Services clients or their representatives to authorize the release of their protected, Department-held information to another person or organization.

Please note that substance use and psychiatric records are specially protected by state and federal laws (42 CFR Part 2, 45 CFR Parts 160 & 164) and require separate authorizations. For these records, please separately contact DHHSPrivacyOfficer@dhhs.nh.gov .

If you have any questions regarding this authorization, please contact the DHHS Privacy Office at DHHSPrivacyOfficer@dhhs.nh.gov.

INSTRUCTIONS:

Be sure to fill in all requested information, and please be as specific as possible.

1. Please provide your full name, contact information, and date of birth. You do not need to specify an expiration date for this authorization unless you would like to have it expire sooner or later than 180 days.

Section I:

2. Please tell us what types of records you are looking for. This is very important, as DHHS has multiple programs and databases it will need to search. The more information DHHS has about the records you are requesting, the sooner we can complete your request.

   - ***NOTE:*** If you are seeking records from the Division of Children, Youth, & Families (DCYF) or the Sununu Youth Services Center (SYSC), please contact DCYF at 603-271-4451.
   - ***NOTE:*** If you are seeking records regarding your Child Support case, please contact the Bureau of Child Support at 603-271-4427 or BCSS-CIU@dhhs.nh.gov.
   - ***NOTE:*** If you are seeking records from New Hampshire Hospital (NHH), please contact the Medical Records Unit at 603-271-5300 or MedicalRecordRequests@dhhs.nh.gov.

Section II:

3. Please specify the date range of the records you are requesting. For example, if you have been receiving services from DHHS for several years, but are only looking for a few months' worth of records, you would put the date range for those months. (e.g.; if you are looking for April – June of 2017, you would write that in the space provided) If you are looking for several years' worth of records, simply write the years you are requesting. You may also specify "date of last service" or "date of last discharge."

Section III:

4. Please state the how or for what purpose your records may be used (e.g.; Legal, Medical, Application/Eligibility, etc.)

Section IV:

5. Specify the person or organization who may use your records and to whom you would like DHHS to send your records. This can include an attorney, a doctor's office, or another person or organization.

6. Please read the consent paragraph carefully, and sign the form. If another person is signing on your behalf, the legal documentation authorizing them to sign for you must be provided with the form. This can include a guardianship or executor appointment order from a court, or an authorized legal representative declaration. The Department will not act on your request without proper legal documentation for your representative.

   - ***NOTE:*** If you are requesting the records of a deceased relative for whom *no estate administration has been initiated*, and you are Next of Kin (as defined by NH RSA 332-I:13), please fill out the Affidavit of Next of Kin available on the DHHS website https://www.dhhs.nh.gov/doing-business-dhhs/legal-services/hipaaprivacy-officer and provide the necessary order from the Probate Court.

Completed authorization forms may be submitted to the DHHS Privacy Office by email to DHHSPrivacyOfficer@dhhs.nh.gov or by mail to: NH DHHS Privacy Officer, 129 Pleasant Street, Concord, NH 03301.

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ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED FOR NH DHHS TO DISCLOSE YOUR RECORDS

This authorization will be valid for 180 days after the date of signature, or until: _____

Name: _____ **Address:** _____

☐ *This is a new address (write old address here):* _____

Date of Birth: _____ **Phone #:**_____ **Email:** _____

I. I am requesting disclosure of the following information:

☐ Eligibility Records for State Assistance Programs

☐ Medicaid ☐ Food Stamps (SNAP) ☐ Cash Assistance ☐ Temporary Assistance for Needy Families (TANF)
☐ Aid to the Permanently & Totally Disabled (APTD) ☐ Women, Infants, & Children Nutrition Program (WIC)
☐ Aid to the Needy Blind (ANB) ☐ Old Age Assistance (OAA) ☐ Long-Term Care
☐ Choices for Independence ☐ Other (*please specify*): _____

☐ Public Health Records

☐ HIV/AIDs Testing ☐ Other STD Testing ☐ Other Infectious Disease Testing: _____
☐ Per- and Polyfluoroalkyl Substances (PFAS) Testing ☐ Prescription Drug Monitoring Program
☐ Healthy Home Lead Poisoning Prevention Program (HHLPPP) ☐ Therapeutic Cannabis
☐ Other (*please specify*):_____

☐ Medicaid Billing/Claims Records ☐ Adult Protection Records

☐ Other: (*please specify*): _____

NOTE: Child Protection, DCYF, Child Support, and NHH records must be requested from the program directly on separate forms.

II. I am authorizing the NH Department of Health & Human Services to disclose my protected information, as described above, from the following time period:_____to_____**to the person/entity named below** *(please provide name(s) and address(es)*: _____

_____

III. This information is to be used/disclosed for the following purpose: _____

IV. Statement of Understanding:

- I understand that this authorization will not impact any services I am receiving or will receive from NH DHHS. I understand that the information I authorize a person or entity to receive from NH DHHS may be re-disclosed by that person or entity and no longer protected by federal privacy regulations. I understand this authorization is voluntary and that if I refuse to sign this authorization, NH DHHS will not release my information.
- I understand that I may revoke this authorization at any time by notifying NH DHHS in writing. However, the revocation will not be valid if NH DHHS has already released my information based on this authorization.
- I understand that I can find further information regarding NH DHHS privacy practices and my patient rights in the NH DHHS Notice of Privacy Practices. (https://www.dhhs.nh.gov/documents/dhhs-notice-privacy-practices)

Please sign and date below:

_____ _____ Date: _____
Signature Relationship (if not signed by Client)

_____
Printed Name

If the above signature is that of a guardian, executor, or other authorized representative, please attach the appropriate legal documentation.
Records will not be released if legal documentation is not included.

For Department Use Only	
ID Verification Method: *See instructions on Intranet*	☐ Photo ID ☐ Legal Representation ☐ Signature Comparison ☐ Confirmation of info on file (3 factors) *Please list:* _____ ☐ Other: _____
Date: _____	
Notification Sent to Privacy Office:	☐ Date: _____
Staff Name (Print):	
Staff Title:	