NH Department of Health & Human Services

Request for Access to Client's Own Confidential Information

The following form is to be used by clients of the Department of Health & Human Services (DHHS) to access their own confidential records held and maintained by DHHS.

You may find more information on NH DHHS privacy practices in our Notice of Privacy Practices on our website: https://www.dhhs.nh.gov/doing-business-dhhs/legal-services/hipaaprivacy-officer

INSTRUCTIONS:

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

- Please provide your full name, contact information, and date of birth. Please make sure that the address you give us is your mailing address, so we know where to send the records.

Section I:

1. All requests for access are required to have an expiration date where the release is no longer valid, meaning DHHS cannot release your records after that date without a new signed release from you. You do not need to choose an expiration date of this release unless you would like to have it expire sooner or later than 180 days. The expiration can also be an event, such as "the end of my legal case" or "when I am no longer receiving assistance from DHHS."

Section II:

2. Please tell us what types of records you are looking for. This is very important, as DHHS has many programs and databases it will need to search. The more information we have about the records you are looking for, the sooner we can complete your request. You can request more than one record type per request form.

- ***NOTE:*** **Substance Use Disorder (SUD) records** refer to any information created by, received, or acquired by federally assisted programs for the treatment of substance use disorders as defined in federal regulation 42 CFR Part 2 § 2.11, relating to a patient's past, current, or future substance use treatment.
- ***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 III:

3. This is a statement that you are requesting **DHHS** to release your records to **you**. Please specify a date range for the records you are requesting, such as "January 2019 to April 2018." A date range helps us narrow down the information so we do not give you more than you need.

Section IV:

4. Please read these statements of understanding carefully. State and federal law require that you are informed of your rights when requesting access to your records. If you have questions, please email the DHHS Privacy Office at DHHSPrivacyOfficer@dhhs.nh.gov.

5. Please sign and date the form. If another person is signing for you, you must give DHHS the legal documentation authorizing them to sign for you. This can include an official guardianship order from a court or authorized legal representative declaration.

6. DHHS will need to verify your/your representative's identity before releasing records and may contact you to verify your information. If you are dropping this form off in person, please have a photo ID or other form of identification ready.

You may send your completed form to: NH DHHS Privacy Officer, 129 Pleasant Street, Concord, NH 03301
Or email to: DHHSPrivacyOfficer@dhhs.nh.gov.

NH Department of Health & Human Services

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

NOTE: This form is to be used if you are requesting access to **your own** records. If you would like DHHS to give your records to someone else, please use the Authorization to Disclose form. https://www.dhhs.nh.gov/documents/hipaa-authorization-disclose

Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

_____ **Email:** _____

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

I. **This authorization is valid for 180 days from the date of signature, or until:** _____

II. **I am requesting access to the following types of my information: *(check all services you would like records for)***

☐ 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 (CFI) ☐ Other *(please specify):* _____

☐ Public Health Records

☐ HIV/AIDs Testing ☐ Other STD Testing ☐ Other Infectious Disease Testing:

☐ Per- and Polyfluoroalkyl Substances (PFAS) Testing ☐ Healthy Homes Lead Poisoning Prevention Program (HHLPPP)

☐ Prescription Drug Monitoring Program (PDMP) ☐ Therapeutic Cannabis Program (TCP)

☐ Other *(please specify)*: _____

☐ Medicaid Billing & Claims Records ☐ Adult Protection Records

☐ Substance Use Disorder (SUD) Records as defined by 42 CFR Part 2 § 2.11

☐ Other *(please specify)*: _____

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

III. **I am authorizing the NH Department of Health & Human Services to make my information (described above) from the time period of _____ to _____ available to me.**

IV: **Statements of Understanding:**

- I understand that this request will not impact any services I am currently receiving or will receive from NH DHHS.
- I understand that re-disclosure of my information by NH DHHS outside of this request is prohibited without additional written permission from me.
- I understand that NH DHHS will make this information available to me within 30 days of this request, or, if NH DHHS cannot provide my information within 30 days that NH DHHS will notify me of such within 30 days of this request and provide me with an estimate of when my records will be available to me.
- I understand that I may be charged a reasonable cost-based fee for copies of my records as allowed by law.
- I understand that the NH DHHS Notice of Privacy Practices is available to me on the DHHS website (https://www.dhhs.nh.gov/documents/dhhs-notice-privacy-practices)

Please sign and date below:

_____ _____

Signature of Client/Guardian/Authorized Representative Date

_____ _____

Printed Name Relationship if not signed by client

If the above signature is that of a guardian or other authorized representative, please attach the appropriate legal documentation.

Records will not be released if legal documentation is not included.

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