Access to Records Request

Social Security Number:_____ **OR** **Medicaid ID #:**_____

Name:_____ **Phone Number:**_____

Address:_____ **City:**_____

State:_____ **Zip:**_____ **Date of Birth:**_____

I. I receive(d) services from the Department at the following location:

☐ New Hampshire Hospital *Admission Date*_____
☐ Glencliff Home for the Elderly
☐ District Office *Location*_____
☐ Other location *Please specify*_____

II. I am requesting access to the following information:

1. ☐ Medical Records ☐ Billing Records ☐ Other *Please specify the information you wish to access:*

_____

2. ☐ Eligibility Determination Records *Circle the services you applied for and/or receive:*

Medicaid Healthy Kids Other *Please specify the information you wish to access:*

_____

III. I am requesting access to my information for the following time period:

From:_____ To:_____

IV. Please sign below.

Copy Fees: First 25 pages free, $.25 per additional page.

I understand that there may be a fee for the documents and wish to proceed.

_____ _____
Signature Date

_____ _____
Printed Name Notary Name & Seal

If the above signature is that of a personal representative, please attach the appropriate legal documentation.

For Department Use Only

Date received:_____ Date sent:_____ Personal representative verified:_____

2. Extension required ☐ Yes ☐ No Reason_____

3. Approved ☐ Yes ☐ No

_____ _____
Signature /Title Date

Medical Record Information