Authorization for Release of Protected Health Information

Full Legal Name: _____ DOB: _____ (MM/DD/YYYY)

Current Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone #: _____ (Home) _____ (Work) _____ (Cell)

I hereby authorize the following Health Care Provider to disclose the protected health information from the medical records of the individual listed above: _____ (Name of Health Care Provider)

Information is to be **RELEASED TO**: NH Department of Health & Human Services - XEROX
Disability Determination Unit
PO Box 2090
Concord, NH 03302-2090

I understand that the health information I authorize to be disclosed to DHHS may be re-disclosed and no longer protected by federal privacy regulations. I specifically authorize information obtained by this release to be exchanged between DHHS and the US Social Security Administration (SSA) and/or Vocational Rehabilitation (VR) for the purpose of determining eligibility. Information obtained by this release will not be re-disclosed to agencies other than the SSA and/or VR without my additional specific written authorization.

DISCLOSE THE FOLLOWING INFORMATION FOR THE PAST TWO (2) CALENDAR YEARS:

☐ **Complete Records**

Or Check all that apply:

☐ Admission Hx and physical	☐ Mental health notes	☐ Pathology reports
☐ Discharge summary	☐ Psychiatrist's or Psychologist's notes	☐ Pulmonary Function Tests
☐ Copies of Consultations	☐ IQ evaluation	☐ Liver Function Tests
☐ Office notes/Progress notes	☐ Therapies: speech, physical, etc.	☐ X-rays/CAT scans/MRI
☐ Emergency Reports	☐ Surgical Reports	☐ Cardiac Testing

☐ Other, please specify: _____

PURPOSE OF DISCLOSURE: Disability Determination for NH Medicaid (NH Title XIX)

Please read the following statements **CAREFULLY** and **place your initials on the line by those statements which apply to you:**

_____ **I understand** my medical record may contain information in reference to drug and/or alcohol abuse that is governed by Federal Regulation (42 CFR P2) and is prevented from re-disclosure without my express written consent or as permitted by law.

_____ **I specifically authorize** the release of my HIV, AIDS or ARC results or treatment.

_____ **I specifically authorize** the release of my psychiatric, mental health, or neuropsychiatric record.

_____ **I specifically authorize** the release of my genetic testing records if applicable.

REVOCATION: I understand that I may revoke this authorization by notifying DHHS in writing, to the above-noted address, at any time, except to the extent that the authorization has already been used to request information prior to my revocation.

EXPIRATION: This authorization will expire 12 months from the date it was signed.

I understand that this information is necessary for an eligibility determination for NH Medicaid (NH Title XIX) to be made, and that if I do not authorize the release of my medical records and information I may not be able to demonstrate that I qualify for benefits under NH Medicaid.

_____ (Signature of Applicant or Legal Representative) _____ (Signature of Witness) _____ (Date)

Authority of representative: ☐ Parent of minor ☐ Guardian ☐ Other: _____

NOTE: Copies of applicable documentation for the representative's authority MUST be attached.

A PHOTOCOPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL

Return to: Your Local District Office