NH Department of Health and Human Services
Granite Advantage Health Care Program
P.O. Box 3778, Attn: Granite Advantage Health Care Program Manager
Concord, NH 03302-3778

BFA Form 320A
01/19
Fax #: 603-271-5623

Beneficiary Authorization for Licensed Medical Professional to Release Protected Health Information
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Granite Advantage Health Care Program

This form authorizes a licensed medical professional to release to the Department of Health and Human Services (Department) a beneficiary's protected health information (PHI) related to the licensed medical professional's certification of the beneficiary as medically frail. This form should be completed by the beneficiary and given to the licensed medical professional who is completing the Licensed Medical Professional Certification of Medical Frailty Form.

The beneficiary **MUST** return a copy of this form along with a copy of the Licensed Medical Professional Certification of Medical Frailty Form to the Department. The forms may be sent to the Department by mail at the address above, by fax to 603-271-5623, by submitting forms to NH EASY, or bringing the forms to a local district office. The forms can be submitted through NH EASY by logging on to nheasy.nh.gov, accessing the Granite Advantage Community Engagement page and uploading the forms. A beneficiary may upload the forms to NH EASY or bring the forms to their local district office ***only*** if the licensed medical professional has certified that the beneficiary is medically frail.

Part I. Beneficiary Information (please print)

Last Name:	First Name, Middle Initial:	Date of Birth MM/DD/YYYY
Residential Street Address (if homeless write N/A):	City, State, Zip Code:	Phone #: ( )

Part II. Purpose of the Disclosure The purpose of the disclosure of PHI pursuant to this release is to verify the licensed medical professional certification that the beneficiary is medically frail and that the beneficiary is accordingly exempt from the Granite Advantage Health Care Program community engagement requirements. I understand that if I do not authorize the release of this information, I will not be able to demonstrate that I qualify for an exemption with the necessary completion of the Licensed Medical Professional Certification of Medical Frailty Form.

Please check all that apply below:

☐ I hereby authorize the following licensed medical professional to disclose my protected health information for the purposes described above:

Name of Medical Professional: _____
Organization: _____Telephone #: (_____) _____--_____
Address: _____

☐ In addition, I hereby authorize the following specific disclosures (Place your initials on the line by those statements which apply)

_____ I specifically authorize the release of my mental health treatment records.
_____I specifically authorize the release of my HIV and AIDS results and/or treatment.

_____ I specifically authorize the release of my alcohol and/or drug abuse treatment records in accordance with 42 CFR Part 2.

_____ Other (specify): _____.

- ☐ I give authorization for my protected health information to be released to the following individual or organization:

  Name: Granite Advantage Health Care Program Manager
  Organization: Department of Health and Human Services
  Address: DHHS, Granite Advantage Health Care Program, P.O. Box 3778, Concord, NH 03302-3778 or Fax# 603-271-5623
- ☐ I understand this authorization may be revoked by notifying the Department of Health and Human Services in writing to the address above.
- ☐ This authorization will expire one year from the date it is signed.

_____ _____

Signature of Beneficiary or Duly Authorized Legal Representative Date

If you have any questions regarding this form, please call the Department's Medicaid Customer Services number at 1-844-275-3447 (1-844-ASK-DHHS).