NH Department of Health & Human Services

Division of Long Term Supports and Services (LTSS) – Bureau for Family Centered Services (BFCS)

Authorization for Release of Protected Health and Education Information to BFCS

INSTRUCTIONS FOR COMPLETING AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH AND EDUCATION INFORMATION TO BFCS

NOTE: Please complete a separate form for each Health Care Provider, Associate, or school.

- Write in the name and date of birth (DOB) of the person whose records you want released to BFCS. Please write date of birth in MM/DD/YYYY format.
- PURPOSE OF DISCLOSURE describes why BFCS is requesting this information. Listed are SMS and PIH family support. Information may be used by your SMS and/or PIH staff to best provide services to your family.
- DISCLOSURE DATES include the start and end dates of services. If services are still continuing, please list today's date as the end date.
- COMPLETE RECORDS – checking this box allows of the release of ALL records listed in this box. To specify the release of only certain record types, do not check the Complete Records box, and instead check the boxes next to the record type(s) you would like released.
- The sections SENSITIVE HEALTH INFORMATION and SUBSTANCE USE DISORDER RECORDS require specific permission to be released. To have any records in these two sections released, you must check the box next to the records you agree to have disclosed.
- REVOCATION – the release of protected health and education information may be revoked at any time, in writing.
- EXPIRATION – the ability to release protected health and education information under this authorization will expire twelve (12) months from the date it is signed. A new authorization will need to be signed after that 12-month period ends in order for any other information to be released.
- Read the release thoroughly and then sign, print, and date the form at the bottom where indicated.
  - **Please note:** if Guardian or Other are checked, copies of applicable legal documentation for the representative's authority must be attached (Guardianship Order, Authorized Representative Declaration, etc.)

GLOSSARY OF TERMS

- **504 Plan** – Accommodation plan for students who can learn within a general education environment with stated modifications.
- **Agents of BFCS** are employees of community-based organizations who provide services on behalf of BFCS. (e.g. Amoskeag Health)
- **Bureau for Family Centered Services (BFCS)** administers programs and services for children and youth, from birth to 21 years, with special health care needs and their families. It includes SMS and PIH Family Support.
- **Division of Long Term Supports and Services (LTSS)** – A division of DHHS that includes the Bureau of Family Centered Services (BFCS), Bureau of Developmental Services (BDS) and the Bureau of Elderly and Adult Services (BEAS).
- **Family Centered Early Supports and Services (FCESS)** – Early Intervention supports and services for families and their children age 0-3, who have a developmental delay, disability or chronic condition that impacts development.
- **Individualized Education Plan (IEP)** – An educational document for children ages 3 to- 21 years, focusing on special education and related services.
- **Individualized Family Service Plan (IFSP)** – A **written treatment service plan** based on in-depth assessment of the child's needs and the needs and concerns of the family for children under the age of three years.
- **New Hampshire Department of Health and Human Services (DHHS)**
- **Partners in Health** – Family support, resources, connections to other community services for children with chronic health conditions ages 0-21.
- **Special Medical Services (SMS)** –Title V Funded programs and services for children and youth with special health care needs, which include Health Care Coordination, Comprehensive Nutrition, Feeding and Swallowing Network, Complex Care Clinics/Consultation, and Child Development Clinics.

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

NH Department of Health & Human Services
Division of Long Term Supports and Services (LTSS) – Bureau for Family Centered Services (BFCS)

Authorization for Release of Protected Health and Education Information to BFCS

Full Legal Name: ______________________________ DOB: ______________
MM/DD/YYYY

I hereby authorize the following Health Care Provider or Educator to disclose the protected health and education information from my records:

______
Name and Address of Health Care Provider or Educator

Information is to be **RELEASED TO**: NH Department of Health & Human Services (DHHS)
Division of Long Term Supports and Services-Bureau for Family Centered Services,
129 Pleasant Street, Thayer Building
Concord, NH 03301

PURPOSE OF DISCLOSURE: For eligibility determinations, ongoing care, communication, and consultation for Special Medical Services (SMS) including: health care coordination, nutrition, feeding & swallowing consultation; complex care consultation, and child development clinics, and Partners in Health (PIH) family support program.

I understand that the information I authorize to be disclosed to BFCS and its agents* may be re-disclosed and no longer protected by federal privacy regulations. This information will otherwise not be subject to re-disclosure by BFCS without my additional specific *WRITTEN* authorization, except as authorized by law. I understand that exchange of my information may be via electronic transmission, e.g. fax, email, cell phone, or internet.

DISCLOSE THE FOLLOWING INFORMATION FROM ____________ to ____________.

☐ Complete Records (or check all appropriate boxes below)

☐ Hospital admission & discharge summaries	☐ Medical screening, assessments, and/or diagnostic results	☐ Cognitive assessments and/or 3-year evaluations
☐ Consultation reports	☐ Electroencephalograms	☐ Therapies (PT/OT/SLP)
☐ Medical evaluations	☐ Pediatric health maintenance	☐ Educational records (IEP/IFSP/504)
☐ Office/Progress Notes	☐ Behavioral Health	☐ Emergency Reports
☐ Nutrition notes & swallow studies	☐ Developmental screenings/assessments	☐ Surgical reports
☐ Emergency reports	☐ X-Rays/CAT scans/MRI	☐ Mental health records

☐ Other (please specify): ______________________________

SENSITIVE HEALTH INFORMATION: By CHECKING ANY OF THE BOXES BELOW, and by signing this form I specifically release my medical records, which may contain the following sensitive health information.

RELEASE	INFORMATION
☐	My medical records, which may contain information relating to sexually transmitted diseases, if applicable.
☐	My HIV, AIDS or ARC results or treatment, if applicable.
☐	My psychotherapy notes, if applicable.
☐	My genetic testing records, if applicable.

SUBSTANCE USE DISORDER (SUD) RECORDS: By CHECKING THIS BOX and signing this form, I specifically authorize, if applicable**,** the release of any substance use disorder diagnosis, treatment, or referral records in my medical record that is governed by Federal Regulation (42 CFR Part 2) to DHHS for the specific purpose of this authorization. My SUD records may not be re-disclosed except as listed in this authorization form without my express written consent.

☐ **By checking this box, I authorize the release of my SUD diagnosis, treatment or referral records the purposes stated on this form**.

REVOCATION: I understand that I may revoke this authorization by notifying DHHS/BFCS 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 is signed.

I have had an opportunity to review and understand the content of this authorization form. I understand that this information is necessary for an eligibility determination for SMS and PIH 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 these benefits under LTSS/BFCS.

______________________________ ______________
Signature of Applicant or Legal Representative Date

____
Printed Name of Applicant or Legal Representative Authority of representative: ☐ Parent of minor ☐ Guardian ☐ Other: __________

NOTE: If Guardian or Other are checked, copies of applicable legal documentation for the representative's authority MUST be attached (Guardianship Order, Authorized Representative Declaration, etc.)

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