STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth and Families

Form 1722
June 2020

MEDICAL INFORMATION STATEMENT

This side is for the Individual

Name	Date of Birth	Phone Number	**Date of Request**

Street Address	City	State	Zip Code

HISTORY OF ILLNESSES *(Leave blank any items that are unknown)*

	YES	NO		YES	NO
Tuberculosis or other pulmonary illness	☐	☐	Alcohol/drug abuse	☐	☐
Venereal disease	☐	☐	Fainting/dizzy spells	☐	☐
Diabetes	☐	☐	Hypertension	☐	☐
Epilepsy or neurological conditions	☐	☐	Heart Trouble	☐	☐
Mental or emotional disturbance	☐	☐	Serious defects of bones and joints	☐	☐
Malignancies/growths	☐	☐	Other diseases:	☐	☐

If yes regarding any of the above illnesses, remarks are required:

_____

_____

Authorization for Release of Protected Health Information

Purpose of Disclosure: This authorization form is to allow (authorize) your healthcare provider to give (release or disclose) some protected health information to DHHS. DHHS uses this information to verify your state of health.

If you sign this form, you let your healthcare provider give DHHS the information asked for on the other side of this form. You do not have to sign this form. But, if you do not sign this form, your healthcare provider cannot share your health information.

I hereby authorize the healthcare provider I list here to disclose the protected health information specified on the other side of this form to the Division for Children, Youth and Families within DHHS.

Healthcare Provider Name	Company/Practice Name	Phone Number

Street Address	City	State	Zip Code

I understand that the health information I authorize to be disclosed to DHHS may be re-disclosed and no longer protected by federal and state privacy regulations. I understand that DHHS may use the disclosed information to the extent permitted by state and federal law.

Please sign your name and today's date to let your healthcare provider share the health information asked for on the other side of this form.

Signature of Individual or Duly Authorized Legal Representative	**Date**

Authority of Representative: ☐ Parent ☐ Guardian ☐ Other: _____

What if you change your mind? After you sign this form, you can stop your permission by writing a note to DHHS.

When does my authorization end? It will end two years from the date you sign this form (or earlier, if you ask).

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MEDICAL INFORMATION STATEMENT

This side is for the Healthcare Provider

Dear Healthcare Provider:

You are receiving this form because you are a healthcare provider for _____
Print Patient Name

You have been asked to provide the following medical information regarding the patient identified above to verify their state of health. The individual or their legal representative's signature on the other side of the form serves as an authorization to release the protected health information requested below.

Only the following currently licensed healthcare providers are authorized to complete and sign this form—

Please check the corresponding box to indicate your profession:

☐ Physician ☐ Physician Assistant ☐ APRN

Please complete the following information:

Date of Last Physical Exam: _____

SIGNIFICANT HEALTH HISTORY

Identify any significant health history such as, chronic illnesses, hospitalizations, regular medications, or etc.

_____
_____
_____

IMMUNIZATIONS

For All Adult Household Members and Caregivers

	Dates of Immunizations	**Date of Illness**
Pertussis (Whooping Cough)		
Influenza (annually)		

For Children Only **Copy of the Current Immunization Record MUST be Attached**

Is the child up-to-date on all immunization as recommended by the American Academy of Pediatrics (AAP), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP), and the American Academy of Family Physicians (AAFP)? ☐ Yes ☐ No

If no please explain _____

_____

IMPRESSIONS OF THE INDIVIDUAL'S PRESENT STATE OF HEALTH

The above-named individual was ☐ found free ☐ not found free of physical and mental impairment which may adversely affect the care or well-being of children.

Other information: _____

_____

Authorized Healthcare Provider Signature **Printed Name** **Date**

Payment of any separate charge for completing this form is the responsibility of the patient.

HEALTHCARE PROVIDER—Please Fax to (603) 271-4729 or
Mail to DCYF Foster Care Program, 129 Pleasant Street, Concord, NH 03301