Department of Health and Human Services (DHHS)
Division of Long Term Supports and Services (DLTSS)
Bureau of Adult and Aging Services (BAAS)

105 Pleasant St.
Concord, NH 03301

BAAS POLICY RELEASE (PR)	
PR NUMBER:	24-23
TO:	All Bureau of Adult and Aging Services staff; Dawn Tierney; Kerrileigh Schroeder
FROM THE OFFICE OF:	Bureau Chief of Adult and Aging Services (BAAS), Wendi Aultman
SIGNATURE:	Wendi Aultman Digitally signed by Wendi Aultman Date: 2024.12.03 15:50:51 -05'00'
SUBJECT:	Release of Protected Health and Non- Protected Health Information For Long Term Care and Adult Protection Services, BAAS Forms 3004, 3735 and 3735a
EFFECTIVE DATE:	**Immediately**

SUMMARY

This Policy Release (PR) releases revisions to BEAS Form 3004, *Authorization For Release of Non-Health Related Information,* BEAS Form 3735, *Authorization For Release of Public Health Information*, and the creation of BAAS Form 3735a, *Authorization For Release of Public Health Information-APS.*

BACKGROUND

Previously BAAS only had one form (BEAS Form 3735) that allowed for the release of Protected Health Information (PHI) which was used to help determine medical eligibility for Long Term Care (LTC) supports and services. This form did not allow for the proper disclosures needed for Adult Protection Services (APS). Therefor an additional form for release of information specific to APS needs has been created.

SYSTEM CHANGES AND PROCEDURES

New HEIGHTS will be updated with new taxonomy for indexing the forms

DESCRIPTION OF REVISIONS MADE TO FORMS

The below forms including their instructions have all been updated to BAAS from BEAS and have also had the following revisions:

- BAAS Form 3735, *Authorization For Release of Public Health Information*
  - *Is now available in Spanish*
  - General updates pertaining to formatting, grammar, readability, and appearance

- BAAS Form, 3004, *Authorization For Release of Non-Health Related Information*
  - *Is now available in Spanish*
  - *Previously attached instruction page is now a separate internal form*
  - General updates pertaining to formatting, grammar, readability, and appearance

IMPLEMENTATION

This policy release is effective immediately. Any prior versions ***and*** any unofficial versions of the above forms must be recycled, and the new version used ***immediately***.

Place an order through the DHHS Warehouse/Logistics via the District Office's Quarterly Forms Order (QFO) when a supply of BAAS Forms 3004, 3735 or 3735a is needed.

BAAS Forms 3004, 3735 and 3735a as well as the Spanish translated versions (when translation is completed) will also be available electronically on the DHHS website at www.dhhs.nh.gov/forms-documents-0.

BAAS Forms 3004, 3735 and 3735a, their Spanish translated versions and the associated internal instructions will also be available internally, for Department staff only, on the (N:) drive upon release of this PR.

FORMS INSTRUCTIONS

Remove and Destroy	Insert/Replace
BEAS Form 3004, *Authorization For Release of Non Health Related Information*, Rev 2012	BAAS Form 3004, *Authorization For Release of Non Health Related Information*, PR # 24-23
N/A	BAAS Form 3004(Sp), *Authorization For Release of Non Health Related Information*, PR # 24-23
N/A	BAAS Form 3004(i), Instructions for *Authorization For Release of Non Health Related Information*, PR # 24-23
BEAS Form 3735, *Authorization For Release of Protected Health Related Information*, Rev 2012	BAAS Form 3735, *Authorization For Release of Protected Health Related Information-LTC*, PR # 24-23
N/A	BAAS Form 3735(Sp), *Authorization For Release of Protected Health Related Information-LTC*, PR # 24-23
BEAS Form 3735(i), *Authorization For Release of Protected Health Related Information*, Rev 2012	BAAS Form 3735(i), Instructions for *Authorization For Release of Protected Health Related Information-LTC*, PR # 24-23
N/A	BAAS Form 3735a, *Authorization For Release of Protected Health Related Information-APS*, PR # 24-23
N/A	BAAS Form 3735a(Sp), *Authorization For Release of Protected Health Related Information-APS*, PR # 24-23
N/A	BAAS Form 3735a(i), *Authorization For Release of Protected Health Related Information-APS*, PR # 24-23

DISTRIBUTION

This PR will be distributed according to the electronic distribution list for BAAS policy releases and will be available internally on the DHHS (N:) drive for staff to access and on the DHHS website at Bureau of Adult and Aging Services (BAAS) General Memos (GM) and Policy Releases (PR) | New Hampshire Department of Health and Human Services (nh.gov) for public access

Authorization To Release Non-Health Related Information

Completion of this form authorizes the disclosure and use of Non-Health Related Information about you.
Please complete all fields to avoid denial of authorization.

Name of Individual: _____ **DOB:** _____

Address *(Street, City, State, Zip)*: _____

Medicaid ID Number: _____ **Phone Number:** _____

The above named individual has applied for services or has been referred the Bureau of Aging and Adult Services (BAAS).

The Department is requesting access to your non-health related information to further assist with the delivery of BAAS services and programs. I hereby authorize _____ to release non-health related records for the individual named above.

Information is to be **RELEASED TO**: NH Department of Health & Human Services (DHHS)
Bureau of Adult and Aging Services (BAAS)
105 Pleasant Street
Concord, NH 03301

TIME FRAME

For dates starting on: _____ and ending on: _____

PURPOSE

Purpose of requested use or disclosure: ☐ Individual requested or ☐ Other: _____

INFORMATION TO BE USED AND DISCLOSED

Describe: _____

_____

DISCLAIMER

- I understand that the information I authorize an individual or an organization to receive, may be redisclosed and no longer protected by federal privacy regulations.
- I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that I may revoke this authorization at any time by notifying BAAS in writing at the address above.

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 expires 12 months after the date of the signature below.

I have read this form and agree to the disclosures above from the types of sources listed above.

_____ _____
Signature of Individual or Legal Representative Date

Authority of Representative: ☐ Guardian ☐ DPOA/POA ☐ Other: _____

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

Authorization For Release of Protected Health Information (PHI)
Long Term Care (LTC)

Name of Individual: _____ **DOB:** _____

Address *(Street, City, State, Zip)*: _____

Medicaid ID Number: _____ **Phone Number:** _____

The above-named individual has applied for services or has been referred the Department of Health and Human Services (DHHS), Bureau of Aging and Adult Services (BAAS), Long Term Care (LTC) program.

New Hampshire Statute 161-F:56, amended and effective July 1, 2002, allows that;

"In the course of an investigation conducted pursuant to this subdivision the department may make inquiries and obtain such information as is necessary to further such investigation."

The Department is requesting access to your Protected Health Information (PHI) to further an investigation into alleged abuse, neglect, or exploitation. I hereby authorize _____ to release the below PHI from the medical records for the individual named above.

Information is to be **RELEASED TO**: NH Department of Health & Human Services (DHHS)
Bureau of Adult and Aging Services (BAAS)
105 Pleasant Street
Concord, NH 03301

PURPOSE OF DISCLOSURE: I understand that medical records and information are necessary for delivery of services and programs as well as investigations within the LTC program. I understand if I do not authorize the release of my medical records and information, I may not be able to demonstrate that I qualify or are otherwise eligible for programs and services under LTC. I authorize PHI and information obtained by this release to be reviewed and exchanged within DHHS for the purposes of determining and/or providing services and completing investigations. I understand that the PHI released or disclosed to DHHS may be re-disclosed for the purpose of these determinations or investigations, and will no longer be protected by federal privacy regulations, such as HIPAA. The records and information obtained by this release will not be otherwise re-disclosed without my additional specific written authorization.

TIME FRAME: The LTC program in compliance with the above statue (161-F:56) is requesting copies of medical records for the past two (2) years and up to twelve (12) months after the date of signature.

AUTHORIZATION: I voluntarily authorize and request disclosure of (including paper, oral, and electronic interchange):

1. All my PHI from medical records, and information about how my impairment(s) affects my ability to complete tasks and activities of daily living, or evaluation and any other records, observations and evaluations that evaluate function.
2. I specifically authorize the release of all records and other information regarding my care as indicated below, if it exists, **check all that apply:**

☐ **Yes** Office and Progress Notes	☐ **Yes** Mental Health Notes
☐ **Yes** Admission History and Physical Exams	☐ **Yes** Psychiatrist's or Psychologist's notes
☐ **Yes** Hospital Discharge Summary	☐ **Yes** Therapy notes- PT/OT/ST
☐ **Yes** Copies of Consultations	☐ **Yes** Other: _____

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 expires 12 months after the date of the signature below.
I have read this form and agree to the disclosures above from the types of sources listed above.

Signature of Applicant or Legal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____

Authority of Representative: ☐ Guardian ☐ DPOA/POA ☐ Other: _____

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

Authorization For Release of Protected Health Information (PHI)
Adult Protective Services (APS)

Name of Individual: _____ **DOB:** _____

Address *(Street, City, State, Zip)*: _____

Medicaid ID Number: _____ **Phone Number:** _____

The above named individual has applied for services or has been referred the Department of Health and Human Services (DHHS), Bureau of Aging and Adult Services (BAAS), Adult Protective Services (APS) program.

New Hampshire Statute 161-F:56, amended and effective July 1, 2002, allows that;

"In the course of an investigation conducted pursuant to this subdivision the department may make inquiries and obtain such information as is necessary to further such investigation."

The Department is requesting access to your Protected Health Information (PHI) to further an investigation into alleged abuse, neglect, or exploitation or assisting you in obtaining support and services.
I hereby authorize _____ to release the below PHI from the medical records for the individual named above.
Information is to be **RELEASED TO**: NH Department of Health & Human Services (DHHS)
Bureau of Adult and Aging Services (BAAS)
105 Pleasant Street
Concord, NH 03301

PURPOSE OF DISCLOSURE: I understand that medical records and information are necessary for delivery of services and programs as well as investigations within the APS program. I understand if I do not authorize the release of my medical records and information, I may not be able to demonstrate that I qualify or are otherwise eligible for programs and services under APS. I authorize PHI and information obtained by this release to be reviewed and exchanged within DHHS for the purposes of determining and/or providing services and completing investigations. I understand that the PHI released or disclosed to DHHS may be re-disclosed for the purpose of these determinations or investigations, and will no longer be protected by federal privacy regulations, such as HIPAA. The records and information obtained by this release will not be otherwise re-disclosed without my additional specific written authorization.

TIME FRAME: The APS program in compliance with the above statue (161-F:56) is requesting copies of medical records for the past two (2) years and up to twelve (12) months after the date of signature.

AUTHORIZATION: I voluntarily authorize and request disclosure of (including paper, oral, and electronic interchange):

1. All my PHI from medical records, and information about how my impairment(s) affects my ability to complete tasks and activities of daily living, or evaluation and any other records, observations and evaluations that evaluate function.
2. I specifically authorize the release of all records and any other information regarding my care as indicated below, if it exists, **check all that apply:**

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☐ **Yes** Admission History and Physical Exams	☐ **Yes** Psychiatrist's or Psychologist's notes
☐ **Yes** Hospital Discharge Summary	☐ **Yes** Therapy notes- PT/OT/ST
☐ **Yes** Copies of Consultations	☐ **Yes** Other: _____

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Signature of Witness: _____ Date: _____

Authority of Representative: ☐ Guardian ☐ DPOA/POA ☐ Other: _____

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