Authorization Form

For the Disclosure of Protected 42 CFR Part 2 Patient Records by NH DHHS to an Entity Without a TPR

This form is to be used by DHHS clients to allow NH DHHS to disclose the client's specially protected substance use disorder (SUD) records (42 CFR Part 2) to a third party with a **non-treating provider relationship** with said client.

A "**treating provider relationship**" (TPR) exists when a patient receives diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required. This means that if you have been, are currently being, or are scheduled to have a consultation or be evaluated, diagnosed, and/or treated medically by a provider, a TPR exists between you and that provider. If your authorization is meant for a provider with whom you have a TPR, please use the **Substance Use Disorder Record Release – With TPR** on the Privacy web page.

A "**non-treating provider relationship**" (non-TPR) exists when there is no consultation, evaluation, diagnosis, or treatment by a person and/or entity, such as a law firm, research institution, or third party payer (i.e. insurance companies).

INSTRUCTIONS:

Be sure to fill in all requested information, and please be as specific as possible. Please also note that this document must be notarized before the Department can take any action on your request.

Section I:

- Please provide your full name, contact information, and date of birth. You do not need to specify an expiration date for this authorization unless you would like to have it expire sooner or later than 180 days or after a certain event (e.g.: conclusion of litigation, end of treatment, when you turn a certain age, etc.).

Section II:

- Please provide the name and address of the recipient entity that does **not** have a treating provider relationship with you. If the entity is not a third-party payer, you will need to identify the specific people who are allowed to have access to your information. For example, if you are authorizing a release to a law firm, you must include the names of any attorneys, paralegals, or other staff that will be handling your SUD records. A general designation, such as "all attorneys at ABC Law firm" is **not** sufficient for this purpose.

- Please describe how much and what kind of information may be disclosed, including an explicit description of any substance use disorder information to be disclosed. This should be as limited as possible to reasonably meet the purpose of the disclosure.

- Describe the purpose of the disclosure; this should be as specific as possible. (e.g. "for use in determining my eligibility for benefits/services;" "For use in providing my treatment;" etc.)

Section III:

- Please read the consent paragraph carefully, and sign the form. Remember, this form **must** be notarized. If another person is signing on your behalf, you must provide the legal documentation authorizing them to sign for you. This can include a guardianship order from a court or an authorized legal representative declaration. The Department will not act on your request without proper legal documentation for your representative.

- Please send completed form to:

NH DHHS Privacy Officer
Office of Legal & Regulatory Services
129 Pleasant Street
Concord, NH 03301
DHHSPrivacyOfficer@dhhs.nh.gov

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ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED FOR DHHS TO DISCLOSE RECORDS

Section I:

Name: _____ **Address:** _____

Date of Birth: _____ **Phone #:** _____ **Email:** _____

This authorization will be valid for **180 days** after the date of signature, or until the following date or event: _____ _____.

Section II:

I hereby authorize the **New Hampshire Department of Health & Human Services** to disclose to:

1.) _____ _____
(General Designation) Name of entity to whom disclosure is to be made) Address

_____ _____
(Name of organization) City State Zip

2.) _____ _____
(Name of person to whom disclosure is to be made) Address

_____ _____
(Name of organization) City State Zip

If you need to authorize more people to receive your SUD information, you may use a separate sheet of paper.

the following information:

☐ Substance Use Disorder Records

☐ Evaluation Records ☐Diagnosis Records ☐ Treatment Records ☐ Medication Records

☐ Attendance/Compliance Records ☐ Other (please specify): _____

from the following time period: _____ for the following purpose: _____.

Section III:

STATEMENT OF UNDERSTANDING: I understand that my substance use disorder records are protected under NH state law and the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. **42 CFR Part 2 prohibits unauthorized disclosure or re-disclosure of these records.** I also understand that I may revoke this consent at any time by notifying NH DHHS in writing. However, I understand that the revocation will not be valid if DHHS has already released my information based on this authorization, and that in any event this consent expires automatically as provided above.

I have been provided a copy of this form.

Please sign and date below:

_____ **Date:** _____
Signature of Client/Guardian/Authorized Representative

_____ _____
Printed Name Notary Public/Justice of the Peace

If the above signature is that of a guardian or authorized representative, please attach the appropriate legal documentation. Records will not be released if proper documentation is not included.

My Commission Expires: _____

(notary seal)

Please send completed form to: NH DHHS Privacy Officer, 129 Pleasant Street, Concord, NH 03301

For Department Use Only

Date Completed: _____ Staff Initials: _____ Date Revoked: _____ Staff Initials: _____