

NH Department of Health & Human Services
Request for Access to Client's Own Confidential Information

The following form is to be used by clients of the Department of Health & Human Services (DHHS) to access their own confidential records held and maintained by DHHS. (Confidential records may include: program, health, mental health, or substance use disorder records.)

You may find more information on NH DHHS privacy practices in our Notice of Privacy Practices on our website:

<https://www.dhhs.nh.gov/oos/hipaa/publications.htm>

INSTRUCTIONS:

Be sure to fill in all requested information, and please be as specific as possible.

- Please provide your full name, contact information, and date of birth. Please make sure that the address you give us is your mailing address, so we know where to send the records.

Section I:

1. All requests for access are required to have an expiration date where the release is no longer valid, meaning DHHS cannot release your records after that date without a new signed release from you. You do not need to choose an expiration date of this release unless you would like to have it expire sooner or later than 180 days. The expiration can also be an event, such as “the end of my legal case” or “when I am no longer receiving assistance from DHHS.”

Section II:

2. Please tell us what types of records you are looking for. This is very important. DHHS has many programs and databases that it will need to search. The more information you give us about the types of records you are looking for, the sooner we can complete your request. You can use this one form to request more than one type of record.

NOTE: Substance Use Disorder (SUD) records refer to any information created by, received, or acquired by federally assisted programs for the treatment of substance use disorders as defined in federal regulation 42 CFR Part 2 § 2.11, relating to a patient's past, current, or future substance use treatment. If you check the box requesting “SUD records” you will be provided with the SUD related records held or maintained by DHHS.

Section III:

3. This is a statement that you are requesting **DHHS** to release your records to **you**. Please specify a date range for the records you are requesting, such as “January 2019 to April 2018.” A date range helps us narrow down the information so we do not give you more than you need.

Section IV:

4. Please read these statements of understanding carefully. State and federal law require that you are informed of your rights when requesting access to your records. If you have questions, please email the DHHS Privacy Office at DHHSPrivacyOfficer@dhhs.nh.gov.
5. Please sign and date the form. If another person is signing for you, you must give DHHS the legal documentation authorizing them to sign for you. This can include an official guardianship order from a court or authorized legal representative declaration.
6. DHHS will need to verify your/your representative's identity before releasing records and may contact you to verify your information, or your representative's permission to act for you. If you are dropping this form off in person, please have a photo ID or other form of identification ready.

You may send your completed form to: NH DHHS Privacy Officer, 129 Pleasant Street, Concord, NH 03301

Or email to: DHHSPrivacyOfficer@dhhs.nh.gov.

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

NOTE: This form is to be used if you are requesting access to **your own** records. If you would like DHHS to give your records to someone else, please use the Authorization to Disclose form. <https://www.dhhs.nh.gov/oos/hipaa/documents/authorization.pdf>

Name: _____ **Date of Birth:** _____
Address: _____ **Phone:** _____
_____ **Email:** _____

I. This authorization is valid for **180 days** from the date of signature, or until: _____

II. I am requesting access to the following types of my information: *(check all services you would like records for)*

<input type="checkbox"/> Eligibility Records for State Assistance Programs
<input type="checkbox"/> Medicaid <input type="checkbox"/> Food Stamps (SNAP) <input type="checkbox"/> Cash Assistance <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) <input type="checkbox"/> Aid to the Permanently & Totally Disabled (APTD) <input type="checkbox"/> Women, Infants, & Children Nutrition Program (WIC) <input type="checkbox"/> Aid to the Needy Blind (ANB) <input type="checkbox"/> Old Age Assistance (OAA) <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Choices for Independence (CFI) <input type="checkbox"/> Other <i>(please specify):</i> _____
<input type="checkbox"/> Public Health Records
<input type="checkbox"/> HIV/AIDs Testing <input type="checkbox"/> Other STD Testing <input type="checkbox"/> Other Infectious Disease Testing: <input type="checkbox"/> Per- and Polyfluoroalkyl Substances (PFAS) Testing <input type="checkbox"/> Other: _____

- Community & Home-Based Services Medicaid Billing & Claims Records DCYF/SYSC
- Therapeutic Cannabis Adult Protection Child Support
- New Hampshire Hospital Substance Use Disorder (SUD) Records as defined by 42 CFR Part 2 § 2.11
- Other: _____

III. I am authorizing the NH Department of Health & Human Services to make my information (described above) from the time period of _____ to _____ available to me.

- IV: **Statements of Understanding:**
- I understand that this request will not impact any services I am currently receiving or will receive from NH DHHS.
 - I understand that re-disclosure of my information by NH DHHS outside of this request is prohibited without additional written permission from me.
 - I understand that NH DHHS will make this information available to me within 30 days of this request, or, if NH DHHS cannot provide my information within 30 days that NH DHHS will notify me of such within 30 days of this request and provide me with an estimate of when my records will be available to me.
 - I understand that I may be charged a reasonable cost-based fee for copies of my records as allowed by law.
 - I understand that the NH DHHS Notice of Privacy Practices is available to me on the DHHS website (<https://www.dhhs.nh.gov/oos/hipaa/publications.htm>)

Please sign and date below:

Signature of Client/Guardian/Authorized Representative

Date

Printed Name

Relationship if not signed by client

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

For DHHS Use Only	
ID Verification:	<input type="checkbox"/> Photo ID <input type="checkbox"/> Voice Signature <input type="checkbox"/> Legal Representation <input type="checkbox"/> Confirmation of Info on File <input type="checkbox"/> Other: _____
Date: _____	
Staff Name: _____	
Staff Title: _____	