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

Form 1722
PD 23-04

MEDICAL INFORMATION STATEMENT

Release of Information

Applicant/Household Member: There are two sections to this form. The applicant or household member completes Section 1. A physician, physician assistant or nurse practitioner completes Section 2 for the applicant or household member.

SECTION 1

Name: _____ DOB: _____

Address: _____

Phone number: _____ Email: _____

Role:
- ☐ Foster family care applicant
- ☐ Kinship care applicant
- ☐ Adoptive parent applicant
- ☐ Adult household member
- ☐ Child household member

The above-named individual has applied to foster or adopt a child(ren) or lives in the same household. Per Administrative Rule He-C 6446, the foster family care licensing agency (licensing agency) is required to obtain a medical evaluation and assessment regarding the suitability of the foster parent and other individuals living in in the household or in the family based on their health. Such evaluation and assessment must be based on a physical examination of the applicant and household member(s) conducted not more than one year preceding the date the application is submitted to the licensing agency.

Release of Protected Health Information

Purpose of Disclosure: This authorization form allows (authorizes) the healthcare provider for the individual checked off above to use the individual's protected health information (PHI) in an assessment and evaluation, and findings about the individual for the purpose of an application for foster family care, and to share that PHI and the assessment or evaluation with the licensing agency listed below as part of the application. The healthcare provider is allowed to give (release or disclose) all protected health information listed in section 2 to the licensing agency listed below. The licensing agency shall use~~s~~ the information to verify the health of the individual applicant and/or the health of the household and family members in the household prior to approving the foster family care license.

Licensing agency name: _____ Phone: _____

Address: _____

By signing below, I authorize the following named healthcare provider to release PHI listed below and any other information required by the assessment and evaluation and findings requested on this form, specifically the disclosure of any protected health information that may be specified in **Section 2** of this form, to the above named licensing agency. I specifically release only the mental health information listed in the Health History below. The release of this information is for the limited purpose of evaluating the application as a foster parent. I understand I am not required to sign this form, however, if I do not sign, the healthcare provider cannot share the health information and the licensing agency **will not** be able to process my application.

Healthcare provider name: _____ Practice name: _____

Address: _____ Phone: _____

Patient name: _____ DOB: _____

I understand the health information I authorize disclosed to the licensing agency may be re-disclosed as part of the application for foster family care and no longer protected by federal and state privacy regulations. I understand that the licensing agency may use the disclosed information to the extent permitted by state and federal law. I understand I can revoke my permission at any time by writing to the licensing agency. This authorization will expire 2 years from the date I sign below.

Please sign your name and enter today's date to allow the healthcare provider named above to share the information requested in Section 2.

_____ _____

Signature of individual or duly authorized legal representative *Date*

If signing for a child or minor household member, please indicate the authority of representative as:

☐ Parent ☐ Legal guardian ☐ Other:

MEDICAL INFORMATION STATEMENT

Foster and Adoptive Family Applicant Physical and Mental Health Report

Healthcare provider: To meet the requirements of being a foster and/or adoptive parent, the applicant(s), as well as all household members, must be in good physical and mental health. It is necessary for the licensing agency to determine that the applicant(s) and/or household member(s) have no communicable diseases, have a reasonable life expectancy, and are capable, physically and emotionally, of performing the tasks and responsibilities associated with caring for up to 6 children, ages 0 – 21. As their healthcare provider, your evaluation of the individual identified above and findings will assist the licensing agency in determining the physical wellness and capabilities of the applicant(s) and/or household members who are or may be caring for children.

Upon completion, return to the attention of: _____

Licensing Agency name: _____

Address: _____ Phone: _____

SECTION 2

Patient name: _____ DOB: _____

How long has this individual been your patient? _____ *(Months/Years)*

Date of last physical exam*: _____ *Must have taken place within the last 12 months.

The individual or their legal representative's signature in Section 1 of the form serves as an authorization to release the protected health information requested below.

Health History

Check any and all health difficulties:

☐ Allergies	☐ Diabetes	☐ High Blood Pressure	☐ Sleep Disorder
☐ Arthritis	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Strokes/Paralysis
☐ Asthma	☐ Hearing	☐ Lung Problems	☐ Tremors
☐ Confusion	☐ Heart Problems	☐ Obesity	☐ Vision
☐ Dementia	☐ Hepatitis	☐ Poor Ambulation	☐ Weak/Frail

Explain any health difficulties indicated above and any other chronic conditions:

_____

_____

_____

Are there any medical condition(s), previously or currently, suffered from that would present a health or safety risk to a child placed in the home? ☐ Yes ☐ No

If yes, explain: _____

_____

Does the patient have a terminal illness that could interfere with their ability to care for a child placed in the home? ☐ Yes ☐ No

If yes, explain: _____

Patient name: _____ DOB: _____

Are there any physical limitations, substance use problems, significant history of physical or mental illness, or any other health conditions that would interfere with the ability to provide satisfactory care to a child placed in the home? ☐ Yes ☐ No

If yes, explain: _____

Have referrals to other medical services, mental health services or treatment for alcohol or substance use disorder ever been made? ☐ Yes ☐ No

If yes, explain: _____

Medications

Are medications currently prescribed? ☐ Yes ☐ No

If yes, please complete the chart below:

Medication	**Dosage and Frequency**	**Reason Prescribed** *(Condition)*

Are there any communicable or infectious conditions/diseases that would present a health or safety risk to a child placed in the home? ☐ Yes ☐ No

If yes, explain: _____

Immunizations – Adult only

Has the patient received the Pertussis (whooping cough) immunization?

☐ Yes Date received: _____

☐ No, due to: ☐ Medically contraindicated ☐ Medically inappropriate ☐ Declined by individual

Has the patient received a flu vaccination during the past 12 months?

☐ Yes Date received: _____

☐ No, due to: ☐ Medically contraindicated ☐ Medically inappropriate ☐ Declined by individual

Immunizations – Children only (Under 18 years)

A copy of the current immunization record MUST be attached.

Patient name: _____ DOB: _____

Is the patient up-to-date on all recommended pediatric immunizations, with the exception of vaccines used for the prevention of COVID-19? ☐ Yes ☐ No

If no, please provide further information as to the reason(s) why:

_____

_____

_____

Has the patient received a flu vaccination during the past 12 months

☐ Yes Date received: _____

☐ No, due to: ☐ Medically contraindicated ☐ Medically inappropriate ☐ Declined by parent/guardian

Medical Professional Findings

Based on my knowledge of the patient listed above and a review of their health history, I know of no medical or mental health factors that would interfere with the safety or health of a child placed in their home. ☐ True ☐ Not true

If not true, please provide the reason(s) why: _____

_____

_____

_____

Authorization to complete and sign this form is limited to the following healthcare providers.
Please check the corresponding box to indicate your profession:

☐ Physician ☐ Physician assistant ☐ APRN

Healthcare provider's name: _____ Phone: _____

Do you wish to be contacted by the licensing agency? ☐ Yes ☐ No

_____ _____

Signature *Date*

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