Authorization for Release of Protected Health Information

Full Legal Name: ______________________________ DOB: ______________
MM/DD/YYYY

Current Address: ____
Street City State Zip Code

Telephone #: ______________ ______________ ______________
(Home) (Work) (Cell)

I hereby authorize the following Health Care Provider to disclose the protected health information from the medical records of the individual listed above: ______________________________
Name of Health Care Provider

Information is to be **RELEASED TO**: NH Department of Health & Human Services - XEROX
Disability Determination Unit
PO Box 2090
Concord, NH 03302-2090

I understand that the health information I authorize to be disclosed to DHHS may be re-disclosed and no longer protected by federal privacy regulations. I specifically authorize information obtained by this release to be exchanged between DHHS and the US Social Security Administration (SSA) and/or Vocational Rehabilitation (VR) for the purpose of determining eligibility. Information obtained by this release will not be re-disclosed to agencies other than the SSA and/or VR without my additional specific written authorization.

DISCLOSE THE FOLLOWING INFORMATION for dates of service: From: 1/1/2013 To: Present

☐ **Complete Records**

Or Check all that apply:

- ☐ Admission Hx and physical
- ☐ Discharge summary
- ☐ Copies of Consultations
- ☐ Office notes/Progress notes
- ☐ Emergency Reports
- ☐ Mental health notes
- ☐ Psychiatrist's or Psychologist's notes
- ☐ IQ evaluation
- ☐ Therapies: speech, physical, etc.
- ☐ Surgical Reports
- ☐ Pathology reports
- ☐ Pulmonary Function Tests
- ☐ Liver Function Tests
- ☐ X-rays/CAT scans/MRI
- ☐ Cardiac Testing
- ☐ Other, please specify: ______________________________

PURPOSE OF DISCLOSURE: Disability Determination for NH Medicaid (NH Title XIX)

Please read the following statements **CAREFULLY** and **place your initials on the line by those statements which apply to you:**

______**I understand** my medical record may contain information in reference to drug and/or alcohol abuse that is governed by Federal Regulation (42 CFR P2) and is prevented from re-disclosure without my express written consent or as permitted by law.

______**I specifically authorize** the release of my HIV, AIDS or ARC results or treatment.

______**I specifically authorize** the release of my psychiatric, mental health, or neuropsychiatric record.

______**I specifically authorize** the release of my genetic testing records if applicable.

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 will expire 12 months from the date it was signed.

I understand that this information is necessary for an eligibility determination for NH Medicaid (NH Title XIX) to be made, and that if I do not authorize the release of my medical records and information I may not be able to demonstrate that I qualify for benefits under NH Medicaid.

______________________________ ______________________________ ______________
Signature of Applicant or Legal Representative Signature of Witness Date

Authority of representative: ☐ Parent of minor ☐ Guardian ☐ Other: ______________________

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

A PHOTOCOPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL