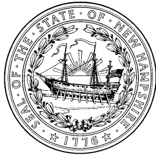
STATE OF NEW HAMPSHIRE
DEPARTMENT OF CORRECTIONS



DIVISION OF MEDICAL& FORENSIC SERVICES
281 N. State St.
Concord, NH 03301
Phone: 603-271-6063
Fax: 603-271-5295

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date Sent: ________________

Patient's Full Name: ____
ID#:_________________ (Last, First, MI)

Date of Birth: ______________________ SSN #: ___________________

I authorize ☐ NH Department of Corrections to ☐ disclose and/or ☐ receive protected health information for the following purpose: **NHDOC provider requesting records:** ______________________________

☐ **Continuity of care** ☐ **Medical Record** ☐ **Attorney** ☐ **Other: (specify)** ___________________________________

To/From:
Name:____ **Phone #:**_______________________

Address:_______________________________________ **Fax #:**__________________________________
____

Type of Information Requested: **Dates of care to be Released :** ____________________________________

☐ **Discharge Summary** ☐ **Laboratory Data** ☐ **Radiology Reports**
☐ **History & Physical** ☐ **EKG** ☐ **Radiology Films**
☐ **Assessments – Medical** ☐ **Assessments –Behavioral Health** ☐ **Physician Orders**
☐ **Consultation** ☐ **Progress Notes – Medical** ☐ **Progress Notes –Psychiatric/Drug Abuse/MH Treatment**
☐ **Operative** ☐ **Nurse Notes** ☐ **Emergency Dept. Record**
☐ **Pain Management Assessment/Treatment Plans**
☐ **Other:** ____

I understand these facts regarding authorization to disclose information by the Division of Medical & Forensic Services through the Medical Records Office:

1. Information released may contain psychiatric and/or drug and alcohol information.
2. Information may only be released which is considered necessary to fulfill the purpose as stated in the release.
3. Release of information may result in advantages and disadvantages to the offender or former offender. The best interests of the offender or former offender should be served by the authorization to disclose.
4. Consent to disclose information is not a required condition for treatment.
5. This authorization may be revoked in writing at any time, except to the extent that action or information disclosed prior to the date of revocation has occurred.
6. Disclosure of information directly to an offender or former offender shall be under supervision of an appropriate member of the medical records office and/or Health services staff.
7. Re-disclosure of information obtained to persons and/or agencies outside of the Department of Corrections is prohibited with the exception to outside medical consultants involved in active/current treatment of the offender.
8. **If my initials appear here, I specifically authorize the following information to be disclosed by initialing:**

   Drug and/or alcohol abuse or treatment: Initials: ______________
   Psychiatric: Initials: ______________
   HIV (AIDS) testing/treatment: Initials: ______________
   Sexually transmitted disease: Initials: ______________

   Federal Law 42 CFR Part 2 prohibits those receiving information on drugs or alcohol treatment from re-disclosing it unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or is otherwise permitted by 42 CFR Part 2.

9. This authorization shall expire automatically six (6) months from the date of signature.

I hereby give consent freely and voluntarily and acknowledge the expiration date for the authorization of :

____
Expiration date not to exceed six (6) months

Signed this __________________________________day of ____________________, 20 _________.

_________________________________ _______________________________________
(Signature of Offender) **(Signature of Witness)**

____
(Signature of Legal Representative/Guardian)