Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow NH Healthy Families to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to sign this form or give permission to use or share your health information. Your services and benefits with NH Healthy Families will not change if you do not sign this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling member services.
- NH Healthy Families cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the first page.

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth:_____ Member ID Number: _____

I give NH Healthy Families permission to use my health information for the purpose identified or to share my health information with the person or group named below. The purpose of the authorization is:

☐ to allow NH Healthy Families to help me with my benefits and services, or

☐ to permit NH Healthy Families to use or share my health information for_____.

PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on page 2):

Name (person or group): _____

Address:_____

City:_____ State:_____ Zip:_____ Phone: ( ) - _____

I AUTHORIZE NH Healthy Families TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:

☐ All of my health information INCLUDING: genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed:_____); OR

☐ All of my health information EXCEPT (check all boxes that apply):

- ☐ Genetic information, services or tests
- ☐ AIDS or HIV data and records
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

Authorization End Date: _____/ _____ / _____*(date the authorization ends unless cancelled)*

Member Signature:_____ Date:_____/_____/ _____

(Member or Legal Representative Sign Here)

Relationship to Member: _____

If you are the Member's personal representative, please send us copies of those forms (such as power of attorney or order of guardianship).

Mail to: NH Healthy Families 2 Executive Park Dr Bedford, NH 03110 Toll Free: 1-866-769-3085 (TDD/TYY) 1-855-742-0123 Fax: 1-877-502-7255

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) TO RECEIVE INFORMATION

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ *State:* __________ *Zip:* __________ *Phone: (   )   -*

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ *State:* __________ *Zip:* __________ *Phone: (   )   -*

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ *State:* __________ *Zip:* __________ *Phone: (   )   -*

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ *State:* __________ *Zip:* __________ *Phone: (   )   -*

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ *State:* __________ *Zip:* __________ *Phone: (   )   -*

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ *State:* __________ *Zip:* __________ *Phone: (   )   -*

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ *State:* __________ *Zip:* __________ *Phone: (   )   -*

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ *State:* __________ *Zip:* __________ *Phone: (   )   -*

Statement of Non-Discrimination

NH Healthy Families complies with applicable Federal and State civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NH Healthy Families does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, or sexual orientation.
NH Healthy Families:

- •Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - •Qualified sign language interpreters
  - •Written information in other formats (large print, audio, accessible electronic formats, other formats)

- •Provides free language services to people whose primary language is not English, such as:
  - •Qualified interpreters
  - •Information written in other languages

If you need these services, contact NH Healthy Families at 1-866-769-3085 (TDD/TTY 1-855-742-0123.)

If you believe that NH Healthy Families has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievances and Appeals Coordinator, NH Healthy Families, 2 Executive Park Drive, Bedford, NH 03110 Toll Free: 1-866-769-3085 (TDD/TTY 1-855-742-0123.)
Fax 1-866-270-9943.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, NH Healthy Families is available to help you. You may also file a discrimination complaint through the DHHS Office of the Ombudsman who has been designated to coordinate the efforts of NH DHHS's civil rights compliance for the Department: State of New Hampshire, Department of Health and Human Services, Office of the Ombudsman, 129 Pleasant Street, Concord, NH 03301-3857; (603) 271-6941 or (800) 852-3345 ext. 6941, FAX (603) 271-4632 TDD Access: relay NH 1-800-735-2964; E-mail: ombudsman@dhhs.nh.gov.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, Complaint forms are available at https://www.ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TDD 800-537-7697.