Authorization to Disclose Health Information

nh healthy families

Notice to Member:

- Completing this form will allow New Hampshire Healthy Families to share your health information with the person or group that you identify below.
- You do not have to sign this form or give permission to share your health information. Your services and benefits with New Hampshire Healthy Families will not change if you do not sign this form.
- Right to cancel (revoke): If you want to cancel this Authorization Form, fill out the Revocation Form on the next page and mail it to us at the address at the bottom of the page.
- New Hampshire Healthy Families cannot promise that the person or group you allow Plan 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. New Hampshire Healthy Families 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 page.

Member Information:

Member Name (print):_____ Member Date of Birth: ____/____/_____

Member Medicaid ID Number/ Member ID#:_____

I give New Hampshire Healthy Families permission to share my health information with the person or group named below. The purpose of the authorization is to help me with my New Hampshire Healthy Families benefits and services.

Recipient Information:

Name (person/group): Address:_____

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

New Hampshire Healthy Families can share this Health Information: (check all boxes that apply)

- ☐ All of my health information; OR
- ☐ All of my health information EXCEPT:
- ☐ Prescription drug/medication information
- ☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) information
- ☐ Treatment for alcohol and/or substance abuse information
- ☐ Behavioral health services or psychiatric care information
- ☐ Other: _____

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

Member Signature:_____ **Date**:___/____/_____
(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship. If you are signing for the Member or are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

NH Healthy Families - Member Services
2 Executive Park Dr.
Bedford, NH 03110
Toll Free: 1-866-769-3085 Fax: 1-877-502-7255

I want to cancel, or revoke, the permission I gave to New Hampshire Healthy Families to share my health information with this person or group:

Recipient Information:

Member Name (print): _____

Address: _____

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

Authorization Signed Date (if known): _____/_____/_____

Member Information:

Member Name (print): _____ Member Date of Birth: ___/___/_____

Member Medicaid ID Number/Member ID#: _____

I understand that my health information may have already been shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be shared with another person or group.

Member Signature: _____ **Date:**___/___/_____
(Member or Legal Representative Sign Here)
If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

_____

New Hampshire Healthy Families will stop sharing your health information when we get this form. Use the mailing address below. You can also call for help at the number below.

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