Authorization for Release of Protected Health Information

New Hampshire Department of Corrections

Resident Name: Resident Number: Date of Birth:

As a condition of consideration for privileges which may be granted throughout your sentence to include Parole or other lawfully allowed release, . consent must be given for the minimal release of protected health information (PHI), as well as substance abuse records and other personal records deemed necessary to inform parties involved in the decision-making process for the granting of such possible privileges.

I _____ hereby/authorize the New Hampshire Department of Corrections (NHDOC) which may include, Behavioral Health, Medical and Forensic Services, Case Managers, Field Services, or any other necessary department entity, the New Hampshire Adult Parole Board (NHAPB), and/or any other designated entity deemed necessary by the criminal justice and judiciary system, the ability to receive and review information regarding my medical history, mental health records, drug treatment, substance abuse or other such information which is minimally required to perform necessary duties including determining eligibility for Parole, At Home Confinement or similar services by agency officials.

I understand and agree to disclose information/records relating to my diagnosis, urinalysis results, attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, progress or such other information that is minimally required to satisfy agency needs.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts. 160 & 164; and my medical and behavioral health records are protected under HIPAA and by signing this authorization the persons listed above may obtain such records.

☐ I specifically authorize the release of my Substance Abuse (Alcohol/Drug) information from my health record.

_____ - *Place your Initials here to agree to release*

I understand that this authorization is voluntary and that I may withdraw my consent, in writing, at any time, except to the extent that it has already been acted upon. My consent, if not withdrawn, will continue throughout my term of supervision which ends on _____ regardless of my placement and including any time spent on probation parole or prison supervision. I further understand that I might be denied or have certain services or privileges revoked including the privilege of parole if I refuse to consent or withdraw consent to the release of information.

Notice to Individual Requesting the Disclosure. *Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by Title 42 CFR Part 2 and, then the released information may no longer be protected by the HIPAA Federal Privacy Regulation.* ***I am not under the influence of drugs or alcohol. I fully understand my rights and I am signing this Consent voluntarily.***

Client/Patient Name (print)	
Signature of Client/ Patient or Legal Representative*	Date
Printed Name of legal representative and Relationship to patient	

*A copy of the personal representative's legal authority to act on behalf of the patient is attached.

REQUEST TO WITHDRAW AUTHORIZATION (except to the extent that the release has already been acted on)

I withdraw my consent to disclose or obtain health information authorized above. By withdrawing my consent I understand that any privilege of parole or other lawfully allowed release may be subsequently denied or revoked. I also understand that by withdrawing authorization DOC or NHAPB will not continue to seek medical information not already obtained. Additionally, I understand the withdrawal of consent is only effective when the covered entity (third party) receives the withdrawal.

Client/Patient Name (print)	
Signature of Client/ Patient or Legal Representative	Date
Witness Signature	Date
Guardian Signature (if required)	Date

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION: To the extent this release authorized the disclosure of information related to a substance use disorder, 42 CFR part 2 prohibits unauthorized disclosure of these records. This release and notice shall accompany any disclosed record.