Care Coordination Program – NH
State Military Reservation
1 Minuteman Way
Concord, NH 03301
Intake Line: 1-888-989-9924

# Authorization of Disclosure of Protected Information

Client Name: _____ DOB: _____

_____

I, _____, authorize the following to disclose and receive information for the purpose of coordination of care through Care Coordination Program – NH:

**Name/Facility:** NH ARNG Chaplain's Office, Authorized Chaplain or Chaplain's Assistance

**Phone #:** 603-227-1560 **Cell #:** 603-731-3278 **Fax #:** 603-227-1575

**Street Address:** 1 Minuteman Way **Apt/Unit #:** _____

**City**: Concord **State:** NH **Zip Code:** 03301

**E-mail:** _____

**Information to be disclosed:**

You may disclose information and collaborate with the above indicated person/program or program representative regarding participation with Care Coordination Program - NH (CCP-NH) to facilitate referrals, collaborate for continuum of care, advocate for, and/or request emergency financial assistance.

Federal rules prohibit making any further re-disclosure to entities other than the entity identified above.

**If my initials appear below, I request that you do NOT disclose the following information**

☐ I do not authorize release of any information concerning drug and alcohol

☐ I do not authorize release of any information concerning HIV and AIDS

☐ I do not authorize release of any information regarding legal status

I understand that this authorization is voluntary and may be revoked by me at any time. I understand that my health information is protected by the Privacy Rule in accordance with Federal Rules 45 CFR Part 160 and Subparts A and E of Part 164 which requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization, and Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter 1 and 2), and/or State laws.

This authorization is limited to three years from the date of signature below. Further disclosure of information beyond the scope of this authorization is prohibited without specific written authorization. I understand that a fax or photocopy of this authorization will have the same validity as the original authorization.

I understand that by authorizing this release of information, I also release the CCP-NH contracting agent from any legal responsibility or liability that may arise from the release of my information.

Client or Parent/Guardian:_____ Date: _____

Program Staff Witness: _____ Date: _____

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