Connections for Health
Integrated Health Services

COMMUNITY CARE TEAM

AUTHORIZATION TO RELEASE / OBTAIN PROTECTED INFORMATION

Patient name:____Date of Birth: _____________________

I,____authorize the Connections for Health
(patient name)
Community Care Team (CfH CCT), whose members are listed below to disclose and discuss my health care information, including any mental illness, substance use disorders, HIV- related information and state benefit and housing status so that the CFH CCT may help me get assistance by making recommendations and referrals to meet my needs.

I understand that:

- Information in my health record about any alcohol and/or drug treatment is protected under federal laws. It cannot be shared without my written permission unless stated otherwise in the law *42 CFR, Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164*.
- This authorization form does not authorize the release of written or electronic copies of my medical records. It only authorizes discussion regarding my health and care amongst the agencies listed above.
- All members of the CFH CCT sign confidentiality statements and promise to keep my information private. However, if a CFH CCT member is not a health care provider or health plan, or is not covered under federal privacy laws, the released information may not be protected.
- I can cancel this authorization at any time by telling **any member of the CFH CCT** or by notifying **Connections for Health at** cct@CfHnh.com**,** and my health information will no longer be shared at the CFH CCT. The cancellation will not apply to information that has already been disclosed. If I do not want to participate with the CFH CCT, this will **not** limit my treatment, payment, enrollment, or eligibility for benefits.
- This permission shall expire one year from the date of my signature below.

I have read this form and have had any questions answered.

I understand the purpose of form is to authorize permission for the organizations listed above to discuss my health and personal information, including alcohol and/or drug treatment information.

I have been offered a copy of this signed release.

____ ____________________
Patient Signature **Date**

____
Parent/Guardians Signature (if applicable)

____
Name of Reviewer **Organization** (Must be current CFH CCT member listed on page 2.)

* Managed Care Organizations will only be present during discussions of their members.

Updated 01/06/2021

Connections for Health CCT members:

Amedisys
AmeriHealth Caritas*
Beacon Health Strategies*
Brain Injury Association of NH
Community Action Partnership of Strafford County
Community Partners
Connections for Health
Connections Peer Support Center
Core Physicians
Cornerstone VNA
Cross Roads House
Crotched Mountain Community Care
Dover Fire and Rescue
Dover Housing Authority
Easter Seals of NH
Exeter Hospital
Exeter Housing Authority
Families First of the Greater Seacoast
Families in Transition (FIT)
Frisbie Memorial Hospital
Goodwin Community Health
Granite State Independent Living
Haven
Home for All
Homeless Center for Strafford County
Hope on Haven Hill
The Homemakers Services
Lamprey Health Care
My Friend's Place
NH DHHS Bureau of Elderly and Adult Services
NH Harm Reduction Coalition
NH Healthy Families*
NH Housing Finance Authority
OASIS Senior Advisors
OneSky Community Services
Portsmouth Housing Authority
Portsmouth Regional Hospital
Raymond Baptist Church
Rochester Housing Authority
Rockingham VNA
Safe Harbor Recovery Center
Salvation Army, Portsmouth
Seacoast Mental Health Center
Seacoast Pathways/Granite Pathways
ServiceLink of Rockingham County
ServiceLink of Strafford County
SNHS/Rockingham Community Action
Somersworth Housing Authority
SOS Recovery Community Organization
Southeastern NH Services
St. Vincent dePaul Society, Exeter
St. Vincent dePaul Society, Hampton
TASC-Transportation Assistance for Seacoast Citizens
Tri-City Consumers' Action Co-operative
Veterans, Inc.
Waypoint
Welfare Department, City of Dover
Welfare Department, City of Portsmouth
Welfare Department, City of Rochester
Welfare Department, City of Somersworth
WellSense Healthplan*
Wentworth-Douglass Hospital
Wentworth Home Care and Hospice/Amedisys
Womenaid of Greater Portsmouth

Other organizations you wish to add to this release:

For IDNCCT use only

Date revoked: Name & Organization of IDNCCT member receiving revocation:

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