GREATER SEACOAST COMMUNITY HEALTH

STRAFFORD COUNTY PUBLIC HEALTH NETWORK

SEACOAST PUBLIC HEALTH NETWORK

COMMUNITY CARE TEAM

AUTHORIZATION TO RELEASE / OBTAIN PROTECTED INFORMATION

Individual's name:_____Date of Birth: _____

I,_____, authorize the

(PLEASE PRINT Individual's name, same as above)

Strafford County and Seacoast Public Health Networks and all of their Community Care Team (CCT) members to disclose and discuss my health care information, including any mental illness, substance use disorders, HIV- related information and state benefit and/or housing status so that the 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 substance use 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 CCT sign confidentiality statements and promise to keep my information private. However, if a 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 CCT** or by notifying the Seacoast and/or Strafford County Public Health Networks at SCPHN@GoodwinCH.org and Info@seacoastphn.org and my health information will no longer be shared at the CCT meetings. The cancellation will not apply to information that has already been disclosed. If I do not want to participate with the 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 this form is to authorize permission for the organizations who are members of the Community Care Team to discuss my health and personal information, including alcohol and/or substance use treatment information.

I have been offered a copy of this signed release.

_____ _____

Individual's Signature **Date**

_____

Parent/Guardians Signature (if applicable)

_____

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

CCT Member: *Upload document to Drop Box or visit SCPHN.org or SeacoastPHN.org to find link*

Seacoast & Strafford County CCT members:

AmeriHealth Caritas
Beacon Health Strategies
Brain Injury Association of NH
Community Action Partnership of Strafford County
Community Partners
Connections Peer Support Center
Core Physicians
Cornerstone VNA
Cross Roads House
Dover, City of
Dover Fire and Rescue
Dover Housing Authority
Exeter, City of
Exeter Hospital
Exeter Housing Authority
Families First of the Greater Seacoast
Families in Transition (FIT)
Farmington, Town of
Frisbie Memorial Hospital
Fresenius Medical Care
Goodwin Community Health
Granite United Way - Greater Seacoast
Greater Seacoast Community Health
Haven
Healthcare Lite
Home for All (GUW)
Hope on Haven Hill
Infinity Peer Support
Lamprey Health Care
NH DHHS Bureau of Elderly and Adult Services
NH Harm Reduction Coalition
NH Healthy Families
OneSky Community Services
Portsmouth, City of
Portsmouth Health Department
Portsmouth Housing Authority
Portsmouth Regional Hospital
Red's Good Vibes
Rochester, City of
Rochester Housing Authority
Rockingham VNA
Safe Harbor Recovery Center
Seacoast Mental Health Center
Seacoast Pathways/Granite Pathways
ServiceLink of Rockingham County
ServiceLink of Strafford County
SNHS/Rockingham Community Action
Somersworth, City of
Somersworth Housing Authority
SOS Recovery Community Organization
TASC-Transportation Assistance for Seacoast Citizens
Volunteers in Medicine
Waypoint
Well Sense
Wentworth-Douglass Hospital
Willand Warming Center

For CCT use only

Date revoked: _____

Name & Organization of CCT member receiving revocation: _____

Signature of CCT Member: _____