Authorizion to Release Information

Printed Name of Person to Whom the Release of Information Pertains

Case #, RID #, or MID #, if known

I hereby authorize and request:

Name and Address of Individual or Agency Providing the Information:

NH DHHS

All programs and divisions

to provide the following information: Case Detail Information

to:

Name and Address of Individual or Agency Receiving the Information:

TOWN OF HILLSBOROUGH
P.O. BOX 7
HILLSBOROUGH, NH 03244

I grant my permission for the reproduction of the above information to be given to the individual or agency named. Release of confidential information is subject to State and Federal laws. By signing this release, I acknowledge my permission to release the specified information to the individual/agency I have named.

This authorization shall expire 12 months from the date this form is signed.

Information released cannot be re-released by the receiving individual/agency without additional authorization.

Name: _____

Signature: _____ Date: _____

If the signature above is not that of the person to whom the information pertains, the relationship of the signer to that person must be indicated. In addition, the signature must be witnessed.

Relationship

Witness

Date