CarePlus NEW JERSEY
Healthy minds, healthy bodies.

Client Name: _____

ID #:_____ DOB: _____

Request to Inspect or Receive a copy of Protected Health Information

I understand that I have the right to inspect or receive a copy of my protected health information. I understand that there may be a fee for such access and that I will be informed of the fee in advance. I understand that my request to access my records may be subject to some legal limitations and/or limitations established by a licensed healthcare professional to assure my health and safety and the safety of others. I understand that Care Plus may request that I review my PHI in the presence of a Licensed Professional. I also understand that Care Plus NJ will respond to this request in less than 30 days unless I receive notification in writing that it will take longer to fulfill my request.

_____ I wish to visually inspect the records identified below during regular business hours at Care Plus with Care Plus Clinical Staff

_____ I would like a copy of the records identified below to be:

a. _____ Picked up at a designated time and location to be set by Care Plus NJ

b. _____ Mailed to me at the following address: _____

c. _____ Faxed to me at the following fax number:_____

I wish to review/receive the following: **from date** _____ **to date** _____

☐ *Mental Health Records ☐ Substance Abuse Treatment Program Records ☐ Primary Care/Physical Health Records ☐ PESP
(*mental health records includes all programs enrolled in, unless otherwise specified)

The following information: (may include information about alcohol/substance abuse/HIV/AIDS/Hospital Admission/Hospital Discharge/Medical History):

☐ Comprehensive Assessment
☐ Medications
☐ Continuity of Care Document (CCD)
☐ Contact Log(s)
☐ Psychiatric Evaluation
☐ Lab Results
☐ Special Consult
☐ PESP Records
☐ Progress Notes (excludes psychotherapy notes)
☐ Physical Health
☐ Transfer/Discharge Summary
☐ Monthly Summary

☐ Other (specify dates & documents to be released e.g. letter) _____

_____

Signature of Patient or Person authorized by law to give consent: If this authorization has been signed by a personal representative on behalf of an individual, CPNJ staff must verify his/her authority to act on behalf of the individual, and must set forth here (Attach any additional verifying information):

Specify Type of Info: _____

Date _____

Client/Parent/Guardian Signature _____

Print Name _____

If applicable, signature of Minor* _____

(*minors age 14 or older for mental health/physical health are afforded the opportunity to sign or object. Reflect if minor objects to releasing PHI by writing "refused" on the signature line. PHI can still be released if minor objects under parental/guardian etc. authorization. *For substance use records, there is no age limit for the minor to sign or object. Reflect if minor objects to releasing PHI by writing "refused" on the signature line. If minor objects, substance use PHI cannot be released).

CPNJ Witness Signature _____ **CPNJ Witness Printed Name** _____

For use by Care Plus Staff Only

Licensed Professional's comments: _____

_____

Approved as requested ☐ Approved per comments* ☐ Request Denied* ☐

Privacy Officer to review only if not approved as requested; Comments_____

_____