Special Consent for Release of Sensitive Information

Client Name:		Other Names:
ID #:		
DOB:	Address:	Phone:

Purposes for Release

The purpose of this form is to request and authorize Care Plus NJ, Inc to electronically transmit and disclose the sensitive information described below to past, present or future members of my Care Team through EDIE/PreManage and the Collective Medical Network for purposes of enabling members of my Care Team to provide Treatment to me. (See reverse side for answers to some Frequently Asked Questions).

Consent to Release Sensitive Information

I hereby request and authorize Care Plus NJ, Inc to disclose my sensitive information and records as described below through the EDIE/PreManage health information exchange functionality operated by Collective Medical Technologies, Inc. to the members of my Care Team identified below who are connected to or participate in the Collective Medical Network. This consent and request applies to information and records concerning diagnosis and treatment of me as a minor, if applicable.

Amount and Kind of Sensitive Information to be Disclosed [Check **ONE** of the following boxes]

☐ Option #1: Full Care Documentation. Any of the following types of sensitive information or records which are available in Care Plus NJ's electronic record (e.g., clinical notes, discharge summaries, care plans, lab results, medications, etc.) to my Care Team for purposes of providing me Treatment, including:

- Substance use (alcohol or drug) diagnosis and treatment information and any information related to my treatment at, or any records from, any substance use disorder program (including medications, treatment plans, clinical assessments or tests, symptoms, diagnoses, progress notes)
- HIV/AIDS or sexually transmitted disease (STD) diagnosis or treatment information and records
- Mental, behavioral health and developmental disability diagnosis and treatment information and records, whether on an inpatient or outpatient, or voluntary or involuntary basis
- Adult day program service information

☐ Option #2: Limited Care Team & Care Encounter Information. Only my sensitive information limited to identifying: (1) the type of providers who are members of my Care Team, such as providers that specialize in substance use (alcohol or drug) treatment or referral services, mental health (inpatient or outpatient, HIV or sexually transmitted diseases, developmental disability services, adult day programs and Social Services Providers; **AND** (2) the dates, locations and types of encounters with such providers (e.g., associated diagnosis, complaint, service or location codes or information).

☐ Option #3: Opt Out/Not Interested in Participating In

To Whom My Sensitive Information May be Disclosed

The sensitive information and records described above may be disclosed to all of the past, present, and future members of my Care Team (including Health Care Providers, Behavioral Health Providers, and Social Service Providers) may access my sensitive information indicated above to enable them to provide Treatment to me as part of my overall care plan.

Client Signature:		Date:
Legal Representative (if any)	Signature:	Name:
Reason Client is unable to sign (if applicable):		
Relationship to Client: ☐ Parent ☐ Guardian/Conservator ☐ Health Care Power of Attorney ☐ Other Legally Authorized Representative under applicable state law (specify: _____)		