CarePlus NEW JERSEY
Healthy minds, healthy bodies.

Client Name:_____ DOB: _____

CPNJ ID #:_____ SSN: _____

Authorization to Release Protected Healthcare Information from Care Plus NJ records to Outside Persons and/or Entities

Under Federal HIPAA Privacy regulations, Psychotherapy Notes require a separate, discrete authorization. Care Plus NJ does not maintain psychotherapy notes.

I hereby authorize Care Plus NJ to release from my protected health information by**:** ☐ **Verbal,** ☐ **Written,** ☐**Fax,** ☐ **Electronic**

To: (Title of Person):_____ Name of Entity: _____

Address:_____

Type of Program: ☐ *Mental Health Records ☐ Substance Abuse Treatment Program Records ☐ Primary Care/Physical Health Records **(*mental health records includes all programs enrolled in, unless otherwise specified) (Each type of program is govern by different regulations & must be specified.)** The following information:(may include information about *alcohol/substance abuse/*HIV/AIDS) For time period: From:_____ to _____

☐ Comprehensive Assessment ☐ Psychiatric Evaluation ☐ Special Consult ☐ Progress Notes (excludes psychotherapy notes)
☐ Medications ☐ Lab Results ☐ Physical Health ☐ Continuity of Care Document (CCD)
☐ Monthly Summary ☐ Contact Log(s) ☐ Transfer/Discharge Summary ☐ Hospital Admission/Discharge/Medical History
☐ *Alcohol/Substance Use ☐ Urine/Drugs ☐ *HIV/AIDs ☐ All Bergen County PESP Records ☐ Financial/Billing

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

This authorization for use/disclosure is for the purpose(s) of: _____

_____.

This authorization will otherwise expire on (specify date no greater than one year), event or condition:

I understand that Care Plus will not condition my treatment or access to services upon whether or not I sign this authorization.

I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that the revocation/withdrawal will be effective except to the extent that Care Plus NJ, Inc. has already taken action in reliance on my authorization. I further understand that my decision to revoke must be made in writing. My written statement that I want to revoke/withdraw my authorization should be delivered to: Privacy Officer, Care Plus NJ, 40 Eisenhower Drive, Paramus, NJ 07652.

I understand that if I have been referred to Care Plus by either Probation/Parole, Court, DCP&P or any other legal entity, and I choose to revoke/withdraw this authorization, Care Plus will notify the referring entity of this decision. Care Plus will not divulge any other information in regards to my decision to revoke/withdraw this authorization. I further understand that my decision to revoke/withdraw may be a violation of the rules and regulations set forth by the referring legal entity.

Redisclosure of Medical Records:

Information under this release/exchange may be subject to re-disclosure by the recipient and no longer protected by the Federal regulations known as the HIPAA Privacy Rule governing confidentiality of medical records, but it may be confidential under other Federal and State law.

Notice to Recipient of These Records / Redisclosure of Mental Health and Substance Use Disorder Records Prohibited:

This information has been disclosed to you from confidential records protected by NJ State Mental Health (NJAC 10:37-6.79) and/or Federal Substance Use Disorder (42 CFR Part 2) regulations which prohibit you from making further disclosure without the specific, written authorization by the individual(s) to whom it pertains, or unless otherwise required or permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Unless otherwise specified above, this release shall be valid for a period no longer than 3 months for mental health records and 4 months for Substance Use Disorder records.

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

Specify Type of Info: _____

Signature_____ **Print Name** _____

Date_____ 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 with 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).

Witness Signature_____ **Witness Printed Name** _____