CarePlus NEW JERSEY
Healthy minds, healthy bodies.™

Client Name: _____
ID#: _____
DOB: _____

Consent for Release of Protected Health Information to Health Information Exchange(s)

Purpose of Consent to Release Protected Health Information to Health Information Exchange

The purpose of this authorization is to allow you to consent to having your critical protected health information available to those medical providers through an HIE should the need arise so that you are provide d necessary medical treatment in an expedient, safe and coordinated manner. You may choose between two options for sharing information, or not to share any information. See below for further explanation of terms.

Check ONE of the following boxes for Consent [**See below for the description of the information to be shared.**]

☐ **Option #1: Full Consent.** I consent to allow CarePlus NJ NJ to transmit my protected health information to the HIE for the purpose of sharing a **Continuity Care Document** and to receive **ADT alerts** in the event I am admitted to a hospital.

☐ **Option #2: Partial Consent.** I consent to allow CarePlus NJ to share my protected health information to the HIE for the purpose of receiving ADT alerts in the event I am admitted to a hospital.

☐ **Option #3: Opt Out/Do Not Send my PHI to the HIE.** I do not consent to have CarePlus NJ transmit my protected health information to the HIE for any purpose.

What is a Health Information Exchange (HIE)

CarePlus NJ participates in one or more Health Information Exchanges (HIE). The HIE is an electronic platform that maintains patient's protected health information (PHI). Organizations can send a patient's medical information to the HIE, as well as query and retrieve the patient's medical information that another provider sent to the HIE. The sharing of the patient's information increases accuracy, efficiency and cost savings. CarePlus NJ reserves the right to modify and change which HIE platforms it participates with. Please contact the CarePlus NJ Chief Information Officer or Privacy Officer for a list of platforms CarePlus NJ participates in, as this may change. You may choose to opt out of the HIE at any time. However, any information that has previously been uploaded to the HIE will not be deleted and will continue to be available.

Continuity Care Document (CCD)

A Continuity Care Document (CCD) is an electronic report that is used to share summary information about the client & is transmitted electronically via a secure connection. The following is the type of information provided on the CarePlus NJ CCD: Client Name, Date of Birth, Gender, Race, Ethnicity, Marital Status, Language, Phone, Medical Record ID Number, Admission & discharge dates, diagnosis description, Immunizations, Medications, Problems, "Outpatient" enrollment information (admission/discharge/diagnosis/visit), Treatment Goals & Interventions, Lab Orders, Future Scheduled Appointments, Referral Reason on outbound CCD, Care Team (primary & direct workers), Lab Results, Smoking Status & Vitals. You may consent to have your protected health information to the HIE. A CCD can only be transmitted to an HIE that has established an electronic connection with CarePlus NJ. Only medical providers who have a relationship with you may access your information.

Admissions/Discharge/Transfer Alerts (ADT Alerts) [Limited Identifying Information]

CarePlus NJ participates in HIE platforms which sends to CarePlus NJ, a real time alert when you are admitted, discharged or transferred from a hospital. These alerts are transmitted securely via a direct message. This real time alert ensures your CarePlus NJ care team members can follow up with you accordingly. The following is the type of information provided by CarePlus NJ to the HIE for the purpose of receiving an ADT alert: Client Name, Medical Record Number, Date of Birth, last 4 digits of Social Security Number, Gender, Address & Phone. An alert can only be received by CarePlus NJ when an electronic connection has been made with that platform.

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: _____)