CarePlus NEW JERSEY
Healthy minds, healthy bodies.

*Client Legal Name: _____ *DOB: _____
(First, Middle & Last Name)

Date: _____

Authorization to Release Protected Healthcare Information (PHI) from CarePlus NJ records to Outside Persons and/or Entities

Please check which type of program records you are specifically authorizing, at least one must be checked:

☐ Mental Health Records ☐ Substance Use Disorder Treatment Program Records

According to state and federal regulations, Care Plus NJ must conduct a clinical review of all records before they can be released.

This may take up to 30 days to process. If we expect this to exceed 30 days, Medical Records will contact you.

I hereby authorize Care Plus to release my Care Plus records via ☐ **Electronic** ☐ **Verbal** ☐ **Fax** ☐ **Mail**

***To:** _____ **Name of Entity (if applicable):** _____

Address: _____

***Phone #:** _____ **Fax #:** _____ ***Email:** _____

***This authorization for use/disclosure is for the following purpose(s):** ☐Continuity of Care ☐Coordination of Services

☐Maintain/Obtain Disability Benefits ☐Legal Proceedings ☐Other _____

* **Release the following records for the following services:** (check all options below for all records)

*(*may include information about Alcohol/Substance Use/HIV/AIDS/Reproductive Health/Hospital Admission/Hospital Discharge/Medical History)*

☐Intake Evaluation/Comprehensive Assessment
☐Psychiatric Evaluation
☐*Progress Notes & Other Treatment Documents *(including but not limited to medical & psychiatric history, treatment plans, discharge summaries, lab results, medication lists, case management notes & group notes)*
☐Bergen County Psychiatric Emergency Screening Records – PESP (*262-HELP*)

☐ *HIV/AIDS/STI/Reproductive
☐ *Alcohol/Substance Use
☐ Contacts with Others
☐ Financial Records (EOB/Billing Information)
☐ Other (specify dates & documents to be released e.g. letter)
_____
_____

***Release the records for the following timeframe:** From Date _____ To Date_____.

This authorization will expire **one year** from date of signature, unless one of the following is applicable:
☐Resolution of Legal Proceeding ☐End of School Year ☐Resolution of Probation/Parole ☐Resolution with DCP&P ☐One-Time Release
☐Other _____

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: Attn: Privacy Officer, Care Plus NJ, 1 Kalisa Way, Suite 112, Paramus, NJ 07652 and/or email to the Medical Records Department.

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.

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 (Proof of documentation will be required):

☐ Divorce/Separation Decree ☐ Custody Agreement ☐ Guardianship ☐ DCP&P ☐ Court Order ☐ Medical POA ☐ Advance Directive

***Print Name** _____ ***Signature** _____

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).

For questions or additional information, please contact Medical Records.
Phone: 201-649-4466, Ext. 5390 or email Records@careplusnj.org