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

Date ______________________________________

Request a copy of Protected Health Information (PHI)

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

☐ Mental Health Records ☐ Substance Use Disorder Treatment Program Records

I understand:

- I have the right to review or receive a copy of my Health Records. I will be informed in advance if there is a fee.
- I have the opportunity to review my Care Plus records with a Care Plus NJ staff member.
- Care Plus NJ must review all my clinical records prior to them being released to ensure my health and safety and the safety of others.
- Care Plus NJ will respond to this request in less than 30 days unless I receive notification in writing that this request will take longer.
- If the record contains conjoint sessions (marriage, couple, families), all persons over the age of 18 must authorize release.
- My Health Records will be sent electronically unless otherwise specified.

☐ I wish to visually inspect the records identified below during regular business hours 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. ☐ Emailed to me at the following email address: ____
d. ☐ Faxed to me at the following fax number: ____

*** I wish to review/receive the following records:** (check all options below for all records)

☐ 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 (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)

____

***I wish to review/receive the records for the following timeframe:** From Date__________________ To Date _______________________.

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 e.g. Divorce/Separation Decree/Guardianship/DCP&P documents/Court Orders/Durable POA/Advance Directive):

Specify Type of Info: ____

***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