Unified Consent

Client Name: _____ **Client ID:** _____

Title

Unified Health Insurance Portability and Accountability Act (HIPAA) & 42 C.F.R. Part 2 Compliant Consent for Behavioral Health, Substance Use Disorder (SUD), and Related Services

Purpose

This consent authorizes CarePlus NJ, Inc. to use and disclose your Protected Health Information (PHI), including records protected under 42 C.F.R. Part 2, for **Treatment, Payment, and Health Care Operations (TPO)**. It also permits disclosure of information for specific purposes beyond TPO, consistent with federal law.

This single form replaces all prior TPO and Non-TPO consent forms effective January 1, 2026.

This consent does not authorize disclosure of health information to family members, employers, legal representatives, probation/parole, housing agencies, or other non-treating third parties, or for purposes outside of treatment, payment, or health care operations. Such disclosures require a separate authorization or a stand-alone Release of Information.

Program and Entity Authorization

I authorize CarePlus NJ, Inc., including all current and future programs, departments, services, and affiliates, to use and disclose my PHI, including SUD records, for TPO purposes as described in this consent.

Note: For TPO purposes, this consent authorizes **use and disclosure only**; it is **not bi-directional.**

Recipients

Information may be disclosed to:

- My Treating Provider(s)
- Health Plans
- Third-Party Payers
- Business Associates
- Staff and others assisting in operating CarePlus NJ programs

Only the minimum necessary information will be disclosed to carry out the stated purposes.

Description of Information

All records necessary for **Treatment, Payment, and Program Operations**, including information related to any program, service, or department operated by CarePlus NJ, Inc., such as:

- Behavioral health and crisis services
- Substance Use Disorder (SUD) treatment information (**excluding counseling notes unless separately authorized**)
- Reproductive health information, as permitted by law (e.g., contraception, prenatal care, fertility treatment, miscarriage management, abortion services)

Reproductive Health Attestation: I understand that this consent includes reproductive health information, and I acknowledge the protections and limits of disclosure as described above.

This includes clinical, administrative, or operational records needed to coordinate care and ensure program effectiveness across all CarePlus NJ services.

Purpose of Use / Disclosure

For **Treatment, Payment, and Health Care Operations (TPO)** as permitted under HIPAA and 42 C.F.R. Part 2.

Right to Revoke

I may revoke this consent at any time in writing, except to the extent CarePlus NJ or other lawful holders have already acted in reliance on it.

Revocation Contact:

Privacy Officer,

CarePlus NJ, Inc.,

1 Kalisa Way, Suite 112,

Paramus, NJ 07652

Phone: 201-649-4466

Expiration

This consent expires **one year from the date of signing** or upon written revocation.

Refusal to Sign & Consequences

You may refuse to sign this consent. Consequences may include:

- Delay or inability to bill your health plan (full payment may be required)
- Limited coordination of care with other providers
- Possible delays in referrals or continuity of care

Important: CarePlus NJ will **not condition your treatment or access to services on whether you sign this consent.** Signing this consent is voluntary, and you may still receive services even if you choose not to sign, unless service cannot be provided without specific consent. **Emergency treatment will not be withheld** if you choose not to sign this consent.

Redisclosure Notice (42 C.F.R. Part 2)

This information has been disclosed from records protected by **42 C.F.R. Part 2.** Federal rules prohibit any further disclosure of these records unless you provide written authorization or as otherwise permitted by law.

Part 2 records may be subject to redisclosure by the recipient and may no longer be protected under Part 2, except for uses in civil, criminal, administrative, or legislative proceedings against you.

A **general authorization for the release of medical information is NOT sufficient** for redisclosure of Part 2 records. HIPAA rules may also apply to these records, but HIPAA **does not override Part 2 protections.**

Right to Receive a Copy

I understand that I have the right to **receive a copy of this signed consent.**

Minor / Personal Representative Guidance

- **Minors (age 14+)**: May sign or object to release of mental or physical health PHI; parental/guardian authorization may override for non-SUD records.
- **SUD records:** No age limit; minors may authorize release; parental/guardian consent cannot override.
- Personal representatives must provide **documentation verifying authority** to sign.

Acknowledgment

I understand the above and consent to the use and disclosure of my PHI as described.

Expiration and Signature

Print Name: _____ Date: _____

Client/Parent/Guardian Signature: _____

Relationship to Client: _____

If applicable, signature of minor: _____

Compliance Statement

This consent complies with **HIPAA (45 C.F.R. Parts 160 & 164)** and **42 C.F.R. Part 2 (as amended February 16, 2024)**.