

# NJ Children's System of Care

## CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION ABOUT ALCOHOL OR DRUG INFORMATION AND OTHER PROTECTED HEALTH INFORMATION (PHI)

By signing this consent form, you are allowing your health records listed on this form to be disclosed through a secure computer network operated by PerformCare, the Contracted Systems Administrator (CSA) for the NJ Children's System of Care (CSOC), to health care providers whom you identify, that are a part of the CSOC network. The purpose for sharing your health care information is to provide you with better, more coordinated treatment. All drug, alcohol, mental health and physical health care providers or other entities participating in the PerformCare CSA will be able to share (disclose and receive) their records to the health care providers you identify. This will include all places that have provided you services. This includes, drug and alcohol programs, mental health programs, psychologists, clinics, hospitals, clinical laboratories, pharmacies, physicians, health care insurers, Medicare, Medicaid, etc. The list of health care providers and entities are available on the PerformCare website at: [www.performcarenj.org](http://www.performcarenj.org).

There are a number of decisions you will be asked to make when you sign this Consent form.

### 1. Incoming Information PerformCare Receives

**You will be asked to identify the health care providers and entities to whom you are permitting the disclosure of your protected health information (PHI) through the CSA electronic medical record (EMR) and computer network.**

I \_\_\_\_\_, \_\_\_\_\_, authorize  
*(Name of Youth Member)* *(Date of Birth)*

**[Initial** which category applies]

\_\_\_\_\_ All drug, alcohol and mental health programs in which I have been evaluated and/or treated, and other health care providers and entities that are part of the CSOC network to disclose/ make available the health records about me to the CSA EMR and computer network so that PerformCare can authorize services and the healthcare providers I have identified may gain access to and use those records to provide me with treatment.

**\*\* or \*\***

\_\_\_\_\_ Only the following drug, alcohol and mental health programs in which I have been evaluated and/or treated to disclose/make available to the CSA EMR and computer network so that PerformCare can authorize services and the health care providers I have identified may gain access to and use those records to provide me with treatment.

1. \_\_\_\_\_  
*(Name of treatment facility or organization)*
2. \_\_\_\_\_  
*(Name of treatment facility or organization)*
3. \_\_\_\_\_  
*(Name of treatment facility or organization)*

To disclose/make my electronic health record available to PerformCare, the CSA, on behalf of the NJ Children's System of Care via the secure computer network.

### **By initialing below, I acknowledge:**

The following information may be disclosed to PerformCare, the CSA:

_____ My name and other personal identifying information	_____ Discharge plan(s) for alcohol/drug treatment and mental health services
_____ My status as a patient in alcohol and/or drug treatment	_____ Date of discharge from alcohol/drug treatment and mental health services, and discharge status
_____ Initial and subsequent evaluations of my service needs	_____ IEP/School Records
_____ Summaries of alcohol/drug and mental health assessment results and history	_____ Physical health diagnosis and treatment
_____ Summary of alcohol/drug treatment and mental health services plan(s), progress, and compliance	_____ Biopsychosocial Assessment
_____ Attendance in alcohol/drug treatment and mental health services	_____ Other (specify)

### 2. Outgoing PerformCare Information Disclosure

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I further authorize the CSA to disclose this information to the following CSOC-affiliated health care providers so that they can gain access to and use those records for the purpose of providing me with treatment:

Care Management Organization (CMO) (Initial) _____ (Indicate County & Agency Name _____)		
<b>Residential Provider List (Initial All that Apply)</b> <input type="checkbox"/> Daytop NJ <input type="checkbox"/> Newark Renaissance House <input type="checkbox"/> Integrity House <input type="checkbox"/> New Hope <input type="checkbox"/> Straight & Narrow	<b>Outpatient Provider List (Initial All that Apply)</b> <input type="checkbox"/> Catholic Charities <input type="checkbox"/> CPC Behavioral Health <input type="checkbox"/> COPE <input type="checkbox"/> Daytop NJ <input type="checkbox"/> Family Connections <input type="checkbox"/> My Father's House <input type="checkbox"/> Newark Renaissance House <input type="checkbox"/> Genesis Counseling <input type="checkbox"/> Seashore Family Services NJ <input type="checkbox"/> SODAT	<b>Outpatient Exclusive to South Jersey Initiative (SJI)</b> <input type="checkbox"/> Center for Family Services, Inc. <input type="checkbox"/> Drenk <input type="checkbox"/> First Step: Cumberland County <input type="checkbox"/> Solstice Counseling <input type="checkbox"/> Lighthouse <input type="checkbox"/> Preferred Behavioral Health <input type="checkbox"/> Wounded Healer <input type="checkbox"/> Village Wrap, Inc.

I understand that the information available to the health care providers identified above includes all my health information that is in the CSA's computer network, including my drug or alcohol treatment record, mental health diagnosis and treatment information, and any information about other conditions for which I might have received treatment.

\_\_\_\_\_ (Initial)

I understand that I may revoke this consent at any time except to the extent that action has already been taken on it. I can also make changes to my current consent choices by signing a new consent form at any time.

This authorization for my consent automatically expires on \_\_\_\_\_ (date), or one year from the date of my authorizing signature. This consent form will remain in effect until the date, event or condition specified on the Consent form occur.

**Re-disclosure of Information**

Any electronic (or paper form) personal health information about you may not be re-disclosed by Providers/Organizations covered by this Consent to others except as allowed by state and federal laws and regulations. The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent or as otherwise permitted by 42 CFR Part 2.

I understand that I will not be denied services if I refuse to sign this form.

I have a right to receive a copy of this form upon signing.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature of Youth Member

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

**Penalties may be imposed for improper access to or use of your information.** There are penalties for inappropriate access to or use of your electronic health information. If you believe someone has received or accessed your health information improperly, please contact PerformCare at 1-877-652-7624 and ask to speak to a representative from the Quality Department.