NJ Children's System of Care

Administered by PerformCare®

Consent to Release Protected Health Information (PHI)

The New Jersey Children's System of Care, your Physical Health Managed Care Organization (PH-MCO) and PerformCare, your Behavioral Health Administrative Service Organization (BH-ASO) can help you better if they are able to work together with providers that know about you.

By signing this form, you are telling us that it is **OK** for your PH-MCO and BH-ASO listed below in Part 1 and the providers listed in Part 2 to share health information about you with each other. If you do not sign this form, your benefits will stay the same with your PH-MCO and your BH-ASO. The New Jersey Children's System of Care may still share information about you even if you do not sign this form, but only in the way it says in the privacy notice. If you have questions, please ask the person who gave you this form to tell you about your rights or more details about how your health information is shared.

Part 1 Who is the member?

Last Name	First Name	Middle Initial
Medicaid ID number	Date of Birth (MM/DD/YYYY)	Phone Number (with area code)
Address	City	State / Zip Code
Current PH-MCO	Current BH-ASO **PerformCare**	Other Insurer

Part 2 Who can the PHI be given to?

This information can be shared with:

Primary Care Doctor (PCP):

Name | Address/City/State/Zip | Phone#

Medical Health Specialist:

Name | Address/City/State/Zip | Phone#

Behavioral Health Provider (mental health and or substance abuse service provider):

Name | Address/City/State/Zip | Phone#

Behavioral Health Provider (mental health and or substance abuse service provider):

Name | Address/City/State/Zip | Phone#

Other Child Serving System Entity:
(Such as Juvenile Justice, school, Division of Child Protection & Permanency)

Name | Address/City/State/Zip | Phone#

Other

Name | Address/City/State/Zip | Phone#

Name | Address/City/State/Zip | Phone#

Part 3 What PHI can we share?

I say it is **OK** to let the BH-ASO/PH-MCO to use/disclose the health information listed below in Part 3.

My general physical and mental health information will be shared if I sign this form. And **IF** my records have drug and/or alcohol or HIV-related information, I want to share that information as shown below:

Drug and Alcohol Information - IF my records have drug and alcohol information, I want to share it with the BH-ASO and PH-MCO and the providers listed in Part 2 of this form.

☐ Yes, all drug/alcohol information. ☐ No.

HIV/AIDS Information - IF my records have HIV/AIDS information, I want to share it with the BH-ASO and PH-MCO Partners and the providers listed in Part 2 of this form.

☐ Yes. ☐ No.

Part 4 Why are you giving out this PHI?

Sharing this information lets my physical health care and behavioral health care providers and all the BH-ASO and PH-MCO partners communicate treatment needs for service planning.

Part 5 I understand that:

I can take back my OK on this paper at any time. This will not take back the information that was already shared, but it will make sure no more information is shared.

- If I want to take back my OK, I must tell [insert name of entity responsible for maintaining consent]. I can do it in one of these ways:
  - Call them at [Insert telephone number], or
  - Mail to:
    [Insert address]
- I will still get benefits and treatment even if I take back my OK.
- Information that is shared from this form may be shared again by those who receive it. If this happens, it may not be protected by federal or state privacy laws. These laws do not always apply to everyone. **But my drug and alcohol information and my HIV status cannot be shared again further unless I give another OK in writing.**

Part 6 Signature of Member

This authorization of my OK expires on _____, or one year from the date of my authorizing signature.

_____ _____
Signature of Member (Age 14 or older) Date

_____
Print Name

Part 7 Signature of Parent/Legal Guardian

This authorization of my OK expires on _____, or one year from the date of my authorizing signature.

_____ _____
Signature Parent/Legal Guardian Date

_____
Print Name

Part 8 Signature of Authorized Representative (if any)

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own.

_____ _____
Signature of Authorized Representative Date

_____
Print Name

Part 9 Signature of Witness

_____ _____
Signature of Witness Date

_____
Print Name