NJ Children's System of Care

Administered by PerformCare®

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 System 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.

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

_____ My status as a patient in alcohol and/or drug treatment

_____ Initial and subsequent evaluations of my service needs

_____ Summaries of alcohol/drug and mental health assessment results and history

_____ Summary of alcohol/drug treatment and mental health services plan(s), progress, and compliance

_____ Attendance in alcohol/drug treatment and mental health services

_____ Discharge plan(s) for alcohol/drug treatment and mental health services

_____ Date of discharge from alcohol/drug treatment and mental health services, and discharge status

_____ IEP/School Records

_____ Physical health diagnosis and treatment

_____ BioPsychoSocial (BPS) Assessment

_____ Other (specify)

2. Outgoing PerformCare Information Disclosure

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 and Agency Name)*

Residential Provider List (Initial All that Apply)

_____ Daytop NJ
_____ Integrity House
_____ Newark Renaissance House
_____ New Hope

Ambulatory Provider List (Initial All that Apply)

_____ Cape Counseling
_____ Catholic Charities: New Choices
_____ CPC Behavioral Healthcare
_____ COPE
_____ Daytop NJ
_____ Family Connections
_____ Genesis Counseling
_____ My Father's House
_____ Newark Renaissance House
_____ Seashore Family Services NJ
_____ SODAT
_____ TRY IT – Atlantic County

Outpatient Providers: South Jersey Initiative (Initial All that Apply)

_____ Center for Family Services, Inc.
_____ Families Matter LLC
_____ First Step: Cumberland County
_____ Genesis Counseling
_____ Legacy
_____ My Father's House
_____ Preferred Behavioral Health
_____ Seashore Family Services NJ
_____ SODAT
_____ Solstice Counseling
_____ The Wounded Healer dba My Friend's House
_____ 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.