NEW JERSEY DEPARTMENT OF HUMAN SERVICES
Office of Children's Services
CHILD BEHAVIORAL HEALTH SERVICES

Authorization to Release Information

I/We authorize the use/disclosure of information about:
Child's (*Individual's)* Name:

_____

Date of Birth:

_____

1. Person(s) or agency (ies) authorized to use, disclose or receive information:

LIST OF POTENTIAL PARTICIPATING AND APPLICABLE AGENCIES:

Arthur Brisbane Child Treatment Center
Adoption Resource Center (ARC)
Care Management Organization _____
Contracted Systems Administrator-ValueOptions
Youth Case Management _____
Division of Youth and Family Services (DYFS)
County Department of Human Services
Division of Family Services
_____County Division of Health
Case Management Resource Team (CART)

_____County Partnership for Children Implementation Team
Family Support Organization (FSO)
_____County Youth Services Commission
_____County Youth Detention Center
_____County Children's Interagency Coordinating Council (CIACC)
_____County Child Study Teams
_____County Family Court/Probation
_____ Medical Center/Hospital
Children's Crisis Intervention Service (CCIS)
NJ Division of Mental Health Services
NJ Juvenile Justice Commission
NJ Parole Board
NJ Division of Developmental Disabilities
NJ Division of Medical Assistance and Health Services (Medicaid)
NJ Department of Human Services/Partnership for Children

Psychiatric Emergency Screening Program
Mobile Response and Stabilization System
Drug/Alcohol Program _____
Therapist _____
Foster Parent(s) _____
Residential Provider_____
Other _____
Other _____
Other _____

Please identify, by drawing a line through and initialing, any agency(ies) with whom you do not want the information shared.

2. I/We am/are authorizing the participating and applicable agencies' staff to release, exchange or discuss social, medical, psychological, substance abuse and other information, as indicated below, of the above-named child.

   LIST OF INFORMATION TO BE RELEASED:

   _____ School records
   _____ Child Study Team reports
   _____ Court reports
   _____ Discharge/Treatment Summaries
   _____ Medical evaluations/reports
   _____ Psychiatric evaluations/reports
   _____ Psychological evaluations/reports
   _____ Social Assessment/History
   _____ Agency Correspondence
   _____ Neurological Evaluations
   _____ Drug/Alcohol Evaluation/Treatment Records
   _____ Other _____ (Please Specify)
   _____ Other _____ (Please Specify)
   _____ Other _____ (Please Specify)

3. I/We understand that this information is solely for the purpose of planning, implementing and monitoring services for my child (named above) and family members. This information may also be used to review the effectiveness of those services for quality assurance purposes.

   I/We understand that by authorizing this release to the Partnership for Children that the above information may be shared, in whole or in part, with the agencies listed to the extent necessary to develop and implement an individualized service plan. This information may also be shared confidentially to monitor and determine service effectiveness and for other quality assurance purposes. This information may become a part of a participating agency or individual's confidential record. The Partnership for Children requires that all participants respect the confidential nature of the records, information, and the proceedings of any meetings. Further release or use for any other purpose is prohibited and there may be penalties for any unauthorized disclosure of this information. With this release, I/We understand that this information may appear on electronic records.

4. I/We understand that I/We may refuse to sign this authorization and that refusal to sign will not affect the above-named child from obtaining treatment, payment to be made, or the above-named child's eligibility for benefits or services, however, it may affect determination of appropriate level of care. I may inspect or copy any written information used/disclosed under this authorization. I understand that if I refuse to sign this form, the New Jersey State Department of Human Services will not disclose my information to the agencies named above.

5. I/We understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. Substance Abuse/HIV/AIDS Information Only: Further, I understand that if I am authorizing the disclosure of information about substance abuse/HIV/AIDS, I must state the purpose of the disclosure. My purpose in allowing the disclosure of this information is as follows:

   _____
   _____
   _____

7. I/We understand that I/We may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the agency at the address listed on this form. The revocation will be effective on the date that the _____ receives the request.

8. This authorization expires on _____ or six months from the date of the authorizing signature.

9. I/We will receive a copy of this authorization.

Signature (or mark*) of
Parent or Legal Guardian: _____
Date of Signature: _____

Name of Parent or Legal Guardian*:_____

*Copy of Valid Appointment of Guardianship must be attached.

Signature of Child (If age 14 or older): _____
Date of Signature: _____

If Mark is provided in place of signature, the mark must be witnessed:

Witness Signature (if applicable): _____

Witness Name/Title:_____

Participants are required to adhere to the following confidentiality and release of information requirements: records are protected under both Federal (42 CFR P 2), and HIPAA (42 U.S.C. 1301 et seq., 45 CFR 160 & 164) and State statutes (N.J.S.A. 30:4-24.3 and 9:6-8.10a) and regulations (N.J.A.C. 10:37-6.13 through 10:37-1363 et. seq.) and NJDHS Administrative Order 2:01.This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR Part 2.) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse consumers.

New Jersey Department of Human Services
Child Behavioral Health Services
PO Box 700
Trenton, NJ 08625-0700
Phone (609) 292-4741