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| **National Council on Alcoholism and Drug Dependence – NJ/WFNJ SAI/BHI**360 Corporate Blvd, Robbinsville, NJ 08691**Interagency Consent To Release and Request Confidential Substance Use Disorder patient records and other Information and other Individually Identifiable Health Information** |

**I,** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, by signing and dating this document:

 Print Client Name

**I authorize NCADD-NJ to disclose the information about me described below (“My Information”) to any one or all of the agencies/entities checked below (each a “Recipient”), as determined to be necessary:**

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***To Who: Check and complete all that apply:***

🞏 The New Jersey Dept. of Human Services, Division of Family Development \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Designee/Contact

🞏 The County Board of Social Services \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and affiliated Fair Hearing Officials

 (County Name)

🞏 The NJ Division of Child Protection and Permanency (DCP&P) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Designee/Contact

🞏 The Child Protection Substance Abuse Initiative (CPSAI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Designee/Contact

🞏 Toxicology Lab for Urine Drug Screens\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Name of Treatment Provider to or from whom information will be given/obtained

🞏 Molina Medicaid Solutions/NJMMIS, DMHAS payment system, and DCF payment system for eligibility

 status and claims; specifically, for billing information and co-insurances

🞏 Supportive Assistance to Individuals and Families (SAIF)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Designee/Contact

🞏 LogistiCare Medicaid Transportation or Taxi Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designee/Contact

**I also authorize all of agencies/entities I have checked above (each a “Discloser”) to disclose My Information described below to NCADD-NJ.**

**I authorize the following information about me (My Information) to be disclosed to and by NCADD-NJ and the Recipient/Discloser agencies/entities:**

***Amount & Kind - check all that apply:***

🞏 **Welfare Information**, including, but not limited to, stability of substance use disorder, mental health disorder, co-occurring disorder, or lack thereof, case and NJ FamilyCare/Medicaid number, SAIF status, employability status, eligibility/sanction status, benefits, work activity status.

🞏 **Medicaid information and eligibility status**, to ensure integrity of billing procedures and processes across systems.

🞏 **DCP&P Information**, including but not limited to NJ Spirit #, case status, dates and children status, alcohol

and/or drug information, and other protected health information related to assessment, medical assessment results

(current symptoms, history and treatment), and including Special Categories of Information (as defined below).

🞏 **Toxicology Labs** that provide analysis of urine specimens in order to obtain results of urine screens.

🞏 **Employment Information**, including but not limited to case status, work readiness and participation.

 🞏 **Treatment Information**, any and all information relating to my substance abuse disorder and/or treatment records, and other protected health information, including, but not necessarily limited to, such information which relates to assessment (dates, results, history), date of admission, treatment and service plans, psychiatric evaluation results, payment authorizations, progress, attendance, drug test results, discharge summary (date, type, status). This may also include non-sensitive medical information including current symptoms, medical history, and care recommendations, as well as Special Categories of Information (as defined below).

I understand that the **purposes** of these authorized disclosures and requests are: (i) to enable NCADD-NJ Clinical Staff to determine my eligibility for welfare benefits and services, work and employment activities; (ii) establish a record of my participation and progress in treatment, (iii) to authorize payment for and monitor services that I need; and (iv) to coordinate service planning with my Welfare, DCP&P and Treatment Provider Caseworkers. In addition, this consent authorizes case management and consultation to take place with other service providers and potential service providers.

I understand that My Information, including substance use disorder and treatment records and other health information, are protected under the federal regulations governing the confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and Protected Health Informationunder the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Section 1320d, et. seq., as amended, and the regulations there under, including 45 C.F.R. Parts 160 and 164, as well as state confidentiality laws and regulations. I understand that once disclosed, except as required by such laws and regulations, the information may be subject to re-disclosure and no longer protected.

I understand that NCADD-NJ cannot and does not condition its treatment, payment or eligibility for health benefits on my signing of this form. I understand that although I am not required to sign this consent in order to obtain treatment from NCADD-NJ, my eligibility for services provided by the agencies/entities listed on this consent may be affected if I choose not to sign.

I understand that I may revoke this consent in writing at any time except to the extent action has been taken in reliance on it. My written revocation can be mailed to NCADD-NJ Attn: Privacy Officer at the address provided to me on the NCADD-NJ Notice of Privacy Practices. If I revoke my consent, I understand that the listed agencies will be notified and my eligibility for services provided by such agencies/entities may be affected. This consent shall otherwise remain in effect until **two years** from the date of signature on this release. I have had an opportunity to ask questions and had any questions answered, and I fully understand the nature of this authorization and consent and choose to sign it voluntarily.

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If signed by Authorized Representative (check one):

🞏 Permanent Guardian 🞏 Emergency Special Guardian 🞏 Power of Attorney 🞏 Legal Parent 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE TO RECIPIENT:**

* **42 CFR Part 2 prohibits unauthorized disclosure of these records.**
* **Disclosure of Mental Health Information without the authorization of the person who is the subject of such records, or as otherwise provided by law, is prohibited.**
* **State law prohibits the unauthorized re-disclosure of HIV/AIDs Information.**