|  |
| --- |
| **National Council on Alcoholism and Drug Dependence- NJ/Family Violence Option (FVO)**360 Corporate Blvd, Robbinsville, NJ 08691**Interagency Consent To Release and Request Information**  |

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

 Print Client Name

**I authorize, direct and instruct NCADD-NJ and the FVO clinical staff 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:**

#

***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

 Designee/Contact

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

 Designee/Contact

* Domestic Violence Service Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Designee/Contact

* The WFNJ SAI/BHI Initiative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Designee/Contact

**I also authorize, direct and instruct all of agencies/entities I have checked above (each a “Discloser”) to disclose My Information described below to NCADD-NJ and its FVO clinical staff.**

I authorize, direct and instruct the following information about me (My Information) to be disclosed to and by NCADD-NJ and the Recipient/Disclosures agencies/entities: ***Amount & Kind - check all that apply:***

Welfare Information, NJ FamilyCare/Medicaid, SAIF status, employability status, eligibility/sanction status, benefits, work activity status, treatment/service referral and engagement, recommendations for referral to the SAI/BHI with justification, severity of risk, need for housing/safe shelter, information to ensure waivers are appropriately granted based on risk, to coordinate services and safety planning, and to coordinate services on the IRP and/or EA plan.

DCP&P Information, including NJ Spirit #, case status, dates and children status, child safety concerns, family violence information, risk assessment information, collaboration for safety and service planning, and other protected health information related to substance use, mental health, trauma, medical assessment results, including current symptoms, history, and treatment.

Employment Information, including but not limited to, case status, work readiness, and work activity/treatment participation.

Domestic Violence Information, as determined to be necessary related to domestic violence counseling, and/or support groups and/or other services, safe housing, safety planning, the need for court or legal intervention services, children’s services, and service planning; including start date and participation in services.

Treatment Information, Domestic violence and safety concerns including safety plan, stability of substance use disorder, mental health disorder, or co-occurring disorder, including diagnoses/medications, medical conditions/medications, and all treatment history and recommendations employability status, DCPP involvement, eligibility/sanction status, benefits, work activity status.

I understand that the purposes of these authorized disclosures and requests are: (i) to enable NCADD-NJ FVO clinical staff to determine my eligibility for FVO waivers, welfare benefits and services, safe housing/shelter, work and employment activities, (ii) to 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 Service Provider Caseworkers.

I understand that My Information that is Protected Health Information is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and the regulations thereunder, including 45 C.F.R. Parts 160 and 164. I understand that my FVO records and privacy are protected under N.J.S.A. 2A:84A-22.13 through 2A:84A-22.16.I also understand that My Information, that may include substance use and treatment records are protected under the federal regulations governing confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2. 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 located in the Notice of Privacy Practices I was given. If I revoke my consent, I understand that the listed agencies will be notified and my eligibility for services

This consent shall otherwise remain in effect for **6 months** from the date of signature on this release.

**Signature of Client or Authorized Representative** **Date**

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 such records, or as otherwise provided by law, is prohibited.**
* **State law prohibits the unauthorized re-disclosure of HIV/AIDs Information.**