Consent for Release of Confidential Information About Alcohol or Drug Information and Other Protected Health Information (PHI) [Please print]

PerformCARE®

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 CSOC 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 is 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 PerformCare Management Information System (MIS) and computer network.

I, _____ _____ , authorize
(Name of Youth Member) (Date of Birth)

[**Initial** which category applies]

****OR****	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 PerformCare MIS and computer network so that PerformCare can authorize services, and the health care providers and Care Management Organization(s) I have identified on the next page may gain access to and use those records to provide me with treatment.
	Only the following drug, alcohol, and mental health programs in which I have been evaluated and/or treated to disclose/make available to the PerformCare MIS and computer network so that PerformCare can authorize services, and the health care providers and Care Management Organization(s) I have identified on the next page 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 on behalf of the NJ Children's System of Care via the secure computer network.

Consent for Release of Confidential Information About Alcohol or Drug Information and Other PHI

By initialing below, I acknowledge:

The following information may be disclosed to and received by PerformCare:

____ 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 PerformCare to disclose this information (identified above) 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)

Medically Managed Detoxification and Short-Term Residential Providers (Check all that apply)	**Outpatient and Intensive Outpatient Providers** (Check all that apply)	**South Jersey Initiative (SJI): Outpatient and Intensive Outpatient Providers** (Check all that apply)
☐ New Hope Integrated Behavioral Health Care	☐ Acenda Integrated Health ☐ Catholic Charities: New Choices ☐ COPE Center ☐ Family Connections ☐ Genesis Counseling Centers ☐ Iron Recovery and Wellness Center, Inc. ☐ My Father's House	☐ Center for Family Services, Inc. ☐ First Step: Cumberland County ☐ Genesis Counseling Centers ☐ Iron Recovery and Wellness Center, Inc. ☐ Legacy Treatment Services ☐ My Father's House ☐ My Friend's House ☐ Optimal Behavioral Health ☐ Village Wrap, Inc.

_____ (Initial) I understand that the information available to the health care providers identified above includes all my health information that is in PerformCare's MIS and computer network, including my drug or alcohol treatment record, mental health diagnosis and treatment information and information about my diagnosis and treatment for HIV/AIDS, and any information about other conditions for which I might have received treatment.

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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.

Signature of Youth Member:	Date:
Signature of Witness:	Date:

Parent/Guardian: By signing below, I authorize the sharing of the PHI of the youth member identified on page 1. (For disclosures of information re: diagnosis or treatment of a youth member for certain mental health conditions, or HIV/AIDS treatment of a youth member under 13 years of age.)

Signature:	Date:
Print name:	Relationship to Youth Member:

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.

Discrimination is against the law

PerformCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, pregnancy, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation. PerformCare does not exclude people or treat them differently because of race, color, national origin, age, disability, pregnancy, creed, religious affilliation, ancestry, sex, gender identity or expression, or sexual orientation.

PerformCare reduces language barriers to accessing services through the New Jersey Children's System of Care by:

- Providing free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
  - Telecommunication devices such as Device for the Deaf (TDD) and Text Telephone (TTY) systems to enable individuals who are deaf, hard of hearing, or speech-impaired to use the phone to communicate
- Providing language services at no cost to people whose primary language is not English, such as:
  - Qualified interpreter services over the phone via a language line
  - Information written in other languages

If you need these services, contact PerformCare at **1-877-652-7624** or **TTY** (for the hearing impaired) **1-866-896-6975**. We are available 24 hours a day, seven days a week.

If you believe that PerformCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, pregnancy, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation, you can submit a complaint by mail or phone by either calling PerformCare's Quality department at **1-877-652-7624** or by writing to:

PerformCare
Attn: Quality Department
300 Horizon Center Drive, Suite 306, Robbinsville, NJ 08691

If you need help filing a complaint, PerformCare's Quality department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, DC 20201

1-800-368-1019, **1-800-537-7697** (**TDD**)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-language interpreter services

Attention: If you do not speak English, language assistance services are available to you at no cost. Call 1-877-652-7624 (TTY 1-866-896-6975).

Spanish: Atención: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-652-7624 (TTY 1-866-896-6975).

Portuguese: Atenção: Se fala português, encontra-se disponível serviço gratuito de intérprete pelo telefone 1-877-652-7624 (TTY 1-866-896-6975).

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-652-7624 (رقم هاتف الصم والبكم: 1-866-896-6975 :TTY).

Haitian Creole: Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-652-7624 (TTY: 1-866-896-6975).

Chinese Mandarin: 注意：如果您说中文普通话/国语，我们可为您提供免费语言援助服务。请致电：**1-877-652-7624 (TTY 1-866-896-6975)**。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-652-7624 (TTY 1-866-896-6975)** 번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১**1-877-652-7624 (TTY 1-866-896-6975)**।

French: Attention : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-652-7624 (TTY 1-866-896-6975).

Vietnamese: Chú ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-652-7624 (TTY 1-866-896-6975).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-652-7624 (TTY 1-866-896-6975)** पर कॉल करें।

Chinese Cantonese: 注意：如果您使用粵語，您可以免費獲得語言援助服務。請致電 **1-877-652-7624 (TTY 1-866-896-6975)**。

Polish: Uwaga: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-652-7624 (TTY 1-866-896-6975).

Urdu:
توجہ فرمائیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-877-652-7624 (TTY: 1-866-896-6975).**

Turkish: Dikkat: Türkçe konuşuyorsanız dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-877-652-7624 (TTY 1-866-896-6975) numaralı telefonu arayın.

Russian: Внимание: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-652-7624 (TTY 1-866-896-6975).