Authorization for Sharing Health Information

PerformCARE®

This form is used to share your protected health information ("PHI") where your authorization is required by federal and state privacy laws.

HIPAA's privacy regulations require protection of individually identifiable health information. The regulations define "protected health information" as information that relates to the:

- Past, present, or future physical or mental health or condition of an individual.
- Provision of health care to an individual.
- Past, present, or future payment for the provision of health care to an individual.

Protection applies to information collected from the individual or received or created by a health care provider, health plan, health care clearinghouse, or employer, and is maintained or transmitted in any form or medium.

Your authorization allows PerformCare NJ to share your PHI with the person(s) or organization(s) that you choose. You can also choose to allow the person(s) or organization(s) to share your PHI with PerformCare NJ. You can cancel this authorization at any time by submitting a request to PerformCare NJ. Contact Member Services at **1- 877-652-7624 or TTY (for the hearing impaired) 1-866-896-6975** for further instructions.

Part A. Youth Information: (individual whose PHI will be shared)		
Youth first name:		Middle initial:
Last name:	CYBER ID:	
Street address:		
City:	State:	ZIP code:
Youth date of birth:	Daytime telephone number (with area code):	
Email address:		
Email address:		

Part B. Recipient: (person or organization that will receive your PHI)		
The following individual or organization has the right to receive my PHI:		
Do you want the following individual or organization to also share your PHI with us? ☐ Yes ☐ No		
First name:	Last name:	
Organization name (if applicable):		
Address:		
City:	State:	ZIP code:
Telephone number (with area code):	Fax number (with area code):	
Relationship to youth in Part A:	Recipient email:	

Part C. Description of the PHI to be shared:

Tell us what types of PHI can be shared. You can check as many boxes as you want. At least one box must be selected. Note: Some sharing of PHI without your authorization is permitted by state and federal law.

Medical records

☐ All PHI related to my health and the provision of and payment for my health care benefits and services, **except for mental/behavioral health and the medical conditions described under the next check boxes.** Note: Federal law requires a separate authorization to share psychotherapy notes.

☐ Some laws allow you to give specific permission to share PHI regarding certain medical conditions. Please check the boxes below if it is OK for us to share PHI regarding these medical conditions. By checking these boxes, you give permission for all your records containing PHI about these medical conditions to be shared. If you only want to authorize sharing of a subset of records about a certain medical condition, such as records about only one diagnosis, fill out the "Only limited information" section below.

- ☐ Genetic information
- ☐ HIV/AIDS
- ☐ Substance or alcohol use
- ☐ Sexually transmitted disease
- ☐ Abortion and family planning
- ☐ Communicable diseases

Mental/behavioral health records

☐ Some laws allow you to give specific permission to share PHI regarding mental/behavioral health. Please check the box below if it is OK for us to share PHI regarding mental/behavioral health. By checking this box, you give permission for all your records containing PHI about mental/behavioral health, including inpatient treatment, to be shared.

- ☐ Mental/behavioral health (including inpatient treatment)

☐ **Only limited information.** In the box below, describe the PHI you want shared. Examples:

- The claim related to my service on [date].
- Appeal information related to my claim on [date].

Please describe the information you want shared:

Part D. Purpose of this authorization:

This authorization is valid for sharing PHI for the following purposes. (Please check one or both boxes.)

☐ To help diagnose, treat, manage, and/or pay for my health needs.

OR

☐ For the following reason:

This authorization shall be invalid if used for any purpose other than the purpose(s) stated above.

Date:

Part E. Expiration date of this authorization:

This authorization will end automatically one (1) year after the date it was signed unless you select an earlier date. If you would like this authorization to end sooner, please provide the expiration date below.

☐ I would like this authorization to end on _____.

OR

☐ Upon completion of the following event or condition: _____.

Part F. Approval: (You OR your personal representative must sign and date this form in order for it to be processed.)

I understand that this authorization for sharing my PHI is voluntary and is not a condition of eligibility for benefits or payment of claims. I understand that PerformCare NJ must be notified of the event/condition to cancel this authorization. This authorization automatically expires one year after the date it was signed unless you choose an earlier date. I understand that I may cancel this authorization at any time by submitting a request to PerformCare and that canceling this authorization will not affect any action taken pursuant to the authorization prior to my request to cancel.

I also understand that if I cancel this authorization, I should separately notify the individual(s) or organization(s) listed in Part B above if I wish for those individual(s) or organization(s) to no longer share my PHI. I also understand that if the person or organization I authorize to receive my PHI described above is not subject to federal or state health information privacy laws, they may further share my PHI and it may no longer be protected by federal or state privacy laws. I also understand that I or my personal representative have a right to receive a copy of this form and to review my PHI that may be shared because of this authorization.

Young adult/parent signature: By signing below, I authorize the sharing of my PHI as described above.	
Signature of young adult/parent:	Date:

Personal representative information: By signing below, I authorize the sharing of PHI about the young adult listed above. (A personal representative is a person who has the legal authority to make health care decisions on the young adult's behalf. A copy of a power of attorney or other legal health care documents must be on file at PerformCare NJ and submitted with this form.)	
Printed name of personal representative or legal guardian:	
Address of representative:	
Description of personal representative's authority:	
Signature of personal representative:	
Date:	Telephone number:

Addendum to Authorization for Sharing Health Information

Verbal consent

We, the undersigned, attest that the young adult identified in Section A above is **physically unable** to sign this authorization. Verbal consent does not replace the need for documentation showing that another person is the young adult's personal representative and cannot replace this documentation simply because it is inconvenient for the young adult to sign.

Reason for the young adult's inability to sign:

The signatures below indicate:

- The information on this form was communicated to the young adult.
- The young adult indicated their understanding of the information in this authorization.
- The young adult freely gave their consent.

Method of communication to member:

☐ Phone

☐ In person

☐ Other (specify):

Witness printed name:	Witness printed name:
Witness signature:	Witness signature:
Date: / /	Date: / /

Return the completed form to:

PerformCare NJ, 300 Horizon Drive, Suite 306, Robbinsville, NJ 08691
Or Fax number: **1-877-736-9166 (toll-free)**
Or Email: **shared-pcnjhealthinfo@performcarenj.org**

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 করুন: 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).