

Informed Consent Form for Sharing Protected Health and Substance Use Information

[Please print.]

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
 (Printed 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.

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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) and progress
- 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.)
<input type="checkbox"/> New Hope Integrated Behavioral Health Care	<input type="checkbox"/> Acenda, Inc. <input type="checkbox"/> Catholic Charities, Diocese of Metuchen <input type="checkbox"/> Center for Family Services <input type="checkbox"/> CPC Integrated Health <input type="checkbox"/> High Focus Centers <input type="checkbox"/> Iron Recovery and Wellness <input type="checkbox"/> Maryville, Inc. <input type="checkbox"/> Oaks Integrated Care/COPE Center

_____ 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.
 _____ (Initial)

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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 occurs.

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. 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 (if youth is physically unable to sign):	Date:

Parent/Guardian (of a youth member under 13 years of age): 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.)

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

Penalties may be imposed for improper/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.