HJAHC
HENRY J. AUSTIN HEALTH CENTER

☐ Warren ☐ Chambers ☐ Ewing ☐ Bellevue ☐ Family Guidance
☐ Catholic Charities ☐ Rescue Mission ☐ AAMH ☐ Oaks Integrated Care

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

NAME: _____ **DATE OF BIRTH:** _____
ADDRESS: _____ **SOCIAL SECURITY #:** _____
_____ **TELEPHONE #:** _____

I HEREBY AUTHORIZE:

☐ Henry J. Austin Health Center, Inc. (HJAHC) **OR** ☐ **Organization/Individual:** _____
Address: _____
_____
Telephone: _____

TO RELEASE MY CONFIDENTIAL HEALTH INFORMATION, AS DESCRIBED BELOW, TO:

☐ Me **OR** ☐ **Organization/Individual:** _____
Address: _____
_____
Telephone: _____

IN THE FOLLOWING MANNER:

☐ Copies by Mail ☐ Copies by Fax ☐ Copies to be Picked-Up ☐ Inspection ☐ Other: _____

FOR THE FOLLOWING PURPOSE(S):

☐ Doctor's Appointment ☐ School/College ☐ Daycare ☐ Transfer of Care
☐ At the Request of Patient ☐ OTHER (Specify) _____
☐ Pre-Employment: ☐ Form Submitted, or ☐ Form not Submitted
(All employment forms are valid for six (6) months ONLY.)

THIS AUTHORIZATION IS FOR THE USE OR DISCLOSURE OF THE FOLLOWING RECORDS:

☐ Entire Record	**☐ History and Physical**	**☐ Lab Results/Reports**
☐ Immunization	**☐ GYN/PAP Result**	**☐ Dental**
☐ Emergency Record	**☐ X-rays and Other Images**	**☐ Psychotherapy Notes**
☐ Progress Notes	**☐ Mental Health Records**	**☐ AIDS/HIV Information**
☐ Sexually Transmitted Disease	**☐ Abortion**	**☐ Substance Use Records**
☐ Infectious Disease Record		

☐ Other: _____

THIS AUTHORIZATION PERTAINS TO INFORMATION GENERATED ON THE FOLLOWING DATE(S) OR IN THE FOLLOWING TIME PERIOD: _____

SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR RELEASE: I understand that the specific information to be released may include reference to alcohol and drug use, any kind of abuse (*e.g.*, child, domestic, etc.), AIDS/HIV infections, STD's (Sexual Transmitted Diseases), Abortion, Hepatitis B, Hepatitis C, and psychiatric conditions or other sensitive health related information as well as the

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treatment of any of these disorders. If this information is documented in the portion of my medical records authorized for release (as set forth above), I agree to the release of such information pursuant to this authorization. I understand that the release of substance use disorder records protected by 42 CFR Part 2 may require my specific consent, for certain purposes.

MY AUTHORIZATION IS GIVEN FREELY WITH THE UNDERSTANDING THAT: I may refuse to sign this authorization. I may request a copy of this signed authorization. I may revoke this authorization at any time (provided that any such revocation is in writing and submitted to the **Henry J. Austin Medical Records Department at 321 North Warren Street. Trenton, NJ 08618**), except where information has already been released in reliance on my authorization. Henry J. Austin Health Center, Inc., will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. Protected health information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. I may be charged a fee and applicable mailing/postage for a request for copies of my medical records made by a third party.
The State of New Jersey allows 30 days to comply with a record request and walk-ins will be handled accordingly unless there is an emergency. If I am picking up the records personally, I will be required to show a legal form of identification.

UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION SHALL EXPIRE 365 DAYS FROM THE DATE IT IS SIGNED, OR ON THE FOLLOWING DATE, EVENT, OR CONDITION (IF EARLIER):
_____
(Note: If no date/event/condition is provided, the authorization shall expire 365 days from the date it is signed).

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
If Signed by Legal Representative, Relationship to Patient **Signature of Witness**

Created by L.F. 7/26/19

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CONSENT FOR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS COVERED BY 42 CFR PART 2

Henry J. Austin Health Center, Inc. ("HJAHC") provides an array of primary health care services, including substance use disorder services, to its patients. Certain HJAHC personnel or other staff have a primary function of providing substance use disorder diagnosis, treatment, or referral for treatment, and are identified as such providers. Substance use disorder patient records maintained in connection with such providers are protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as well as by federal regulations governing the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2 ("Part 2")). Those HJAHC personnel or other staff whose primary function is the provision of substance use disorder diagnosis, treatment, or referral constitute HJAHC's "Part 2 program."

Federal law and regulations (at 42 CFR Part 2) protect the confidentiality of substance use disorder patient records and impose restrictions upon the disclosure and use of substance use disorder patient records which are maintained in connection with the performance of any Part 2 program. In accordance with 42 CFR § 2.22, the following is a written summary of such federal law and regulations:

- Generally, a Part 2 program may only acknowledge that an individual is present or disclose outside the Part 2 program information identifying a patient as having or having had a substance use disorder in the following instances: (i) the patient's written consent is obtained in accordance with subpart C of Part 2, (ii) an authorizing court order is entered in accordance with subpart E of Part 2, (iii) the patient's records are disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency (42 CFR § 2.51), (iv) the disclosure is for the purpose of conducting scientific research (42 CFR § 2.52), or (v) the disclosure is for the purpose of audit and evaluation (42 CFR § 2.53);
- Violation of the federal law and regulations at Part 2 by a Part 2 program is a crime and suspected violations may be reported to appropriate authorities consistent with 42 CFR § 2.4. Any such report may be directed to the United States Attorney for the District of New Jersey at: U.S. Attorney's Office, 970 Broad Street, 7th Floor, Newark, NJ 07102 (Tel.: (973) 645-2700)); or to the Substance Abuse and Mental Health Services Administration (SAMHSA) office responsible for opioid treatment program oversight at: SAMHSA Opioid Treatment Program Compliance Officer, Region II (Tel: (240) 276-2547).
- Information related to a patient's commission of a crime on the premises of the Part 2 program or against personnel of the Part 2 program is not protected;
- Reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected.

If you suspect your substance use disorder records maintained in connection with HJAHC's Part 2 program were used or disclosed in a way that violates Part 2, please contact HJAHC's Privacy Officer at 609-2785915.

PATIENT CONSENT

I, _____, authorize HJAHC's Part 2 program (including its Medication Assisted Treatment Program Coordinator, Licensed Alcohol and Drug Counselor, and/or Peer Recovery Specialist) to disclose my substance use disorder records maintained in connection with HJAHC's Part 2 program as follows:

For purposes of treatment, including care coordination:

- □ To HJAHC, including members of my treatment team (including my primary care provider or other HJAHC staff members who provide me with treatment and care coordination):

    □ All my substance use disorder records
    □ The following parts of my substance use disorder records:
        □ Clinical notes □ Medications and dosages
        □ Discharge summary □ Substance use history summary
        □ Peer support records □ Other: _____
    □ None of my substance use disorder records

For purposes of payment:

- □ To my primary health insurance company (*e.g.*, Medicare, Medicaid, Blue Cross, Aetna, *et cetera*): _____

    □ All my substance use disorder records
    □ The following parts of my substance use disorder records:
        □ Clinical notes □ Medications and dosages
        □ Discharge summary □ Substance use history summary
        □ Peer support records □ other: _____
    □ None of my substance use disorder records

- □ To my secondary health insurance company (*e.g.*, Medicare, Medicaid, Blue Cross, Aetna, *et cetera*) (if applicable): _____

    □ All my substance use disorder records
    □ The following parts of my substance use disorder records:
        □ Clinical notes □ Medications and dosages
        □ Discharge summary □ Substance use history summary
        □ Peer support records □ Other: _____
    □ None of my substance use disorder records

For additional purposes (if applicable): To authorize HJAHC's Part 2 program to disclose your substance use disorder records to additional individuals and/or entities, such as your other health care providers and/or family members, please complete this section:

- □ To the following individuals or entities (name/address/telephone): _____
  _____

  For the following purpose(s) (*e.g.*, treatment, payment, personal reasons): _____
  _____

  The following records:

  □ All my substance use disorder records
  □ The following parts of my substance use disorder records:
  □ Clinical notes □ Medications and dosages
  □ Discharge summary □ Substance use history summary
  □ Peer support records □ Other: _____
  □ None of my substance use disorder records

I understand that I may revoke this authorization at any time (provided than any such revocation is in writing and submitted to the HJAHC Medical Records Department at Henry J. Austin Medical Records Department at 321 North Warren Street. Trenton, NJ 08618) except to the extent that action has been taken in reliance on it. Acting in reliance on it includes the provision of treatment services in reliance on a valid consent to disclose information to third-party payers.

I understand the conditions of my treatment may be modified up to and including denial of services should I refuse consent to the disclosure of my substance use disorder records, as permitted by state law.

Expiration: This authorization will expire on: _____
(If I do not specify an expiration date, event, or condition, this authorization will expire 365 days from the date it is signed).

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
If Signed by Legal Representative, Relationship to Patient **Date**