AUTHORIZATION FOR DISCLOSURE/RELEASE OF HEALTH INFORMATION

INFORMED CONSENT

I, ____________________, legal guardian for ____________________ (DOB __________) authorize:

1. Immediate Care Children's Psychiatric Center to disclose the following information to ____________________.
   Contact/Agency
2. ____________________ to disclose the following information to Immediate Care Children's Psychiatric Center.
   Contact/Agency

INFORMATION TO BE DISCLOSED

Information is dated from __________ to __________.

Information may include drug and alcohol abuse,
and/or contagious disease documentation, if applicable.

Information to be disclosed (circle any that apply):

1. Medical & psychiatric history/current assessments,
2. Problem list and treatment plan,
3. Clinical record
4. Medication information,
5. Medical and/or clinical test reports(specify)
   ____
6. Discharge summary
7. Other - ____________________

CONTACT(S)

Name
____
Address
____
____
Phone#
____

Name
____
Address
____
____
Phone#
____

PURPOSE OF DISCLOSURE(must describe)
To coordinate patient treatment

I understand:

- My decision to release any information is voluntary.
- I may revoke this consent at any time by presenting my written revocation to ICCPC staff before information is released.
- That revocation does not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- That, unless revoked or I specify a specific expiration date (specify__________), this authorization will expire in 3 months.
- That I may inspect or copy the information disclosed, unless clinically contraindicated as per CFR164.524.
- That any disclosure carries with it the potential for an unauthorized re-disclosure and that such information may not be protected by federal confidentiality rules.
- My child's treatment will not be denied due to refusal to sign this authorization.

____________________	__________	____________________	__________
Patient's legal guardian/ relationship	*Date*	*Witness*	*Date*

____________________	__________
Patient age 14years or older	*Date*

Note to recipient of this information: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law. Federal and State regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Anyone who receives information covered by these regulations, whether obtained legally or not, is prohibited from using the information for any criminal or civil investigation, or prosecution of the patient. *(Federal Regulation* 42CFR part2;N.J.S.A. 26:5C-11)(N.J.A.C. 10:37-6.79(a)3).