State of New Jersey
Department of Human Services
Office of Legal and Regulatory Affairs
P.O. BOX 700
Trenton NJ, 08625

HIPAA Authorization to Disclose Protected Health Information

I, _____(Printed name), DOB:_____ understand that my information, which is retained by the New Jersey Department of Human Services (NJDHS) and/or one of its Divisions/Commission, may not be disclosed to a third party without my expressed written authority, unless permitted or required by law. I hereby authorize the NJDHS to disclose my information to:

Individual's Name or Class of Individuals _____

_____

Organization/Entity (if applicable): _____

Address: _____

Telephone Number: _____ **Fax Number:** _____

Email Address: _____

Specify the Division(s) you are seeking information from:

[ ] Commission for the Blind and Visually Impaired
[ ] Division of Aging Services
[ ] Division of Developmental Disabilities
    [ ]Green Brook Developmental Center
    [ ]New Lisbon Developmental Center
    [ ]Woodbine Developmental Center
    [ ]Hunterdon Developmental Center
    [ ]Vineland Developmental Center
[ ] Division of Deaf and Hard of Hearing
[ ] Division of Disability Services
[ ] Division of Family Development
[ ] Division of Medical Assistance and Health Services
[ ] Division of Mental Health and Addiction Services

Identify the information to be disclosed. (Check all that apply):

[ ] Entire medical[1] record

[ ] Partial medical record - Specify date range and/or the subset of the records being requested.

_____

_____

_____

[ ] Other information (level of detail to be released)- Specify:

_____

_____

_____

[ ] Psychotherapy Records

[ ] Substance Use Disorder (SUD) Records

If the request includes disclosure of SUD information/records, explicitly identify the SUD information that may be disclosed. Use additional pages if necessary.

_____

_____

_____

[ ] HIV/AIDS Related Information

If the request includes disclosure of HIV/AIDS related, explicitly identify the HIV/AIDS related information that may be disclosed. Use additional pages if necessary.

_____

_____

_____

Form of Disclosure:
[ ] Electronic copy [ ] Hard copy

Purpose of this disclosure (ex. Legal/litigation; School; etc.)**:**
Specify:_____

_____

_____

Duration of Disclosure: This authorization shall be in force and effect until: _____ (*Date or Event of Expiration*) at which time this Authorization expires. I understand that upon this expiration date, NJDHS will no longer provide my information to the person or persons stated above, and that if I wish for this person or persons to continue to receive information, I must execute another authorization.

[1] Medical records mean "designated record set" as defined by 45 CFR 164.501. Medical records do not include psychotherapy notes.

I understand that:

- I have the right to revoke (take back) this Authorization, in writing, at any time, except to the extent the NJDHS has taken action in reliance on this authorization, by sending written notice to the Department of Human Services, Attention: HIPAA Privacy Officer, PO Box 700, Trenton, NJ 08625. The exceptions to revocation are fully detailed in the DHS Notice of Privacy Practices. The effective date of the revocation is the date on which the revocation was received by a Department employee. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Department of Human Services, Federal law, or State law.
- SUD information/records cannot be further disclosed by the person or entity named above without the further authorization because 42 CFR part 2 prohibits unauthorized disclosure of these records. (42 CFR 2.32)
- HIV/AIDS related information cannot be further disclosed by the person or entity named above without written consent/authorization of the individual in accordance with N.J.S.A. 26:5C-11. See also N.J.S.A. 26:5C-8.
- NJDHS and its agencies will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.

By signing below, I fully acknowledge and agree to the above terms.

_____ _____

Signature of Individual or Personal Representative

Date

_____

Printed name

_____

Authority of Personal Representative (Provide a copy of the Letters of Guardianship, Power of Attorney, Birth Certificate, Order of Custody, etc.)

If you wish to file a complaint with our agency or get more information on how you can file a complaint with the Department of Human Services, please contact the Privacy Officer in the Office of Legal & Regulatory Affairs, P.O. Box 700 Trenton, NJ 08625, or the Office of Civil Rights, US Department of Health & Human Services, 26 Federal Plaza- Suite 3312, New York, NY 10278.