CIRCLE OF CARE
for Families and Children of Passaic County, Inc.

Consent for Specialized Care Coordination Services
Authorization for Certain Disclosures

This form must be completed by a parent/guardian and contains consent and release forms related to the youth's involvement with Specialized Care Coordination Services.

Youth Name: _____

Date of Initial Contact with Family: _____

Parent/Legal Guardian Name: _____

Street Address Town/City, State Zip Code: _____

Youth's Date of Birth: _____

Youth's Race: _____

Youth's Ethnicity: _____

What language do you prefer to receive communication?: _____

Specialized Care Coordinator Name: _____

General Consent for Specialized Care Coordination Services

I hereby authorize and give my full informed consent to **Circle of Care (CoC).** ("CoC") to provide **Specialized Care Coordination Services** to or on behalf of the above- named youth. This includes the full range of services for the youth.

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of Circle of Care's Notice of Privacy Practices, which contains information on the uses and disclosures of the above-named youth's protected health information, or "PHI." I understand that Circle of Care has the right to change its Notice of Privacy Practices and whenever an important change is made to the notice, Circle of Care will post a new notice in its offices and on its website. I may contact Circle of Care at any time to obtain a current copy of the Notice of Privacy Practices. I may also obtain a copy on the organization's website.

Consent to Use and Disclose Protected Health Information for Treatment, Payment, and Health Care Operations

Circle of Care (CoC) will utilize the above-named youth's protected health information (PHI), including demographic information, received by Circle of Care for the following purposes, and I hereby acknowledge and consent to same:

Treatment: For example, Circle of Care will use and disclose the youth's information to make decisions about the provision, coordination, or management of care, including assessing the appropriate treatment for the youth's conditions and health related needs. It may also be necessary to share information with another provider for the provision, coordination, or management of care. These are only examples of uses and disclosures of information for treatment purposes, and there may be other situations in which Circle of Care will disclose the youth's PHI for treatment purposes.

Payment: For example, Circle of Care may use or disclose information in the youth's records to obtain reimbursement from Medicaid or other payor sources for services rendered by Circle of Care. This may include determination of eligibility for coverage under the appropriate plan, pre-certification and pre-authorization of services or review of services for the purposes of reimbursement. This also includes using or disclosing information to file an appeal of a payment denial or otherwise to collect payment for the services provided by Circle of Care.

Health Care Operations: The youth's records may be used and disclosed in Circle of Care's planning and development operations, including improvements in our methods of operation and general administrative functions. We may also use and disclose PHI in our overall compliance planning, review activities, and arranging for legal, accounting and auditing functions. These are only examples of uses and disclosures that are legally permissible, and there may be other types of legally permissible uses and disclosures that are necessary for Circle of Care to conduct its business operations. In addition, there may be circumstances in which Circle of Care will be legally permitted or required to use and disclose PHI, whether pursuant to a particular law, payor requirement, a subpoena, or a court order.

Disclosures to Authorized Individuals

I understand that Circle of Care may release PHI to a family member, friend, or other person involved in the child/youth's care unless I object. I designate the following person(s) listed below as a person or persons involved with the child/youth's health care and/or payment for health care (circle as applicable), to whom the information circled "yes" below may be released:

Name: _____ Relationship: _____

Address/Phone _____

Health Info: Select Option _____ Payment Info: Select Option _____

Name: _____ Relationship: _____

Address/Phone _____

Health Info: Select Option _____ Payment Info: Select Option _____

Parent/Legal Guardian Contact Information

I,_____,wish to be contacted in the following manner:
(Parent/Legal Guardian Name)

(Please check all that apply)

☐ Home Telephone (h)_____	☐ Detailed Message	☐ Call Back Message Only
☐ Work Telephone (w) _____	☐ Detailed Message	☐ Call Back Message Only
☐ Cell Telephone (c)_____	☐ Detailed Message	☐ Call Back Message Only
☐ Mail to Home Address (below)	☐ Mail to Work Address (below)	

Home Mailing Address:

_____

Work Mailing Address:

_____

I understand that if I have checked the box “detailed message,” I agree that Circle of Care may leave detailed messages at the indicated telephone number, including appointment reminders, insurance/financial issues, and information regarding care/treatment.

Electronic Communication Form

This form reviews the various methods of electronic communication that Circle of Care (CoC) may use while providing **Specialized Care Coordination Services** to the families we serve. The purpose of providing various options for communication is to be able to communicate with families in an efficient and timely manner, while safe-guarding sensitive information and while honoring the preferences of the families we serve.

Email, text, telephone calls, voicemails & videoconferencing are used for the following purposes: meetings or contact with your family and/or systems/providers working to support your youth's referral plan. All matters related to the below-named youth's plan, including progress, strategies for addressing the youth's needs, clarification of services and any other information related to the plan of care for the youth.

Electronic communication is not a substitute for, but works well as a supplement to, regular and direct communication. I understand that, while Circle of Care endeavors to safeguard my information as much as possible and has implemented many safeguards for this purpose, the following risks, among others, are inherent in any type of electronic communication:

- Electronic communication may not be completely private and there are risks in using electronic forms of communication. I will endeavor to make sure that I am communicating in an area that is as private as I need it to be for my or my youth's needs.

- I will use only private, secure networks when communicating with Circle of Care.

- Electronic communication can be a risk if a phone/computer/tablet is lost, stolen or otherwise compromised.

- Electronic communication may be intercepted by unauthorized persons.

- Hackers can invade electronic communication and the device used for such communication, to steal personal and health information or infect the device with an electronic virus.

- When sending sensitive documents, Circle of Care uses encrypted email as an additional safeguard.

- When using videoconferencing technology, Circle of Care uses HIPAA Compliant providers.

- I can revoke this authorization in writing at any time, and the revocation will be effective for periods after the revocation is received by Circle of Care. However, if I revoke this authorization, I understand that I will need to provide a meaningful and workable method for Circle of Care to communicate with me and my youth.

By providing my email address below, I understand that email communication may be used to provide updates on all the following:

- All matters related to the youth's plan, including care coordination with systems/providers, clarification of services and any other information related to the plan of care for the youth.
- Announcements of upcoming events such as community training and support groups and/or
- Organizational communication or information about special events.

In addition to phone calls, please make sure all methods of communication you would like us to use are checked:

☐ Parent/Legal Guardian / Caregiver Email, please enter below.

☐ Youth Email, please enter below.

☐ Texting, please make sure cell number was added above in Contacts.

☐ Voicemail messages, please make sure desired phone numbers were added above in Contacts.

☐ Video Conferencing (without recording) through Teams, Zoom, etc.

_____
Parent/Legal Guardian / Caregiver Email address (for example: name@domain.com)

_____
Alternate Email address (if applicable, for example: name@domain.com)

_____
Youth Email address (if applicable, for example: name@domain.com)

Acknowledgement of above Consents including Electronic Communication and Receipt of Forms

By signing below, I am acknowledging consent for **Specialized Care Coordination Services**, that I have indicated the way I prefer to receive communications and that the Specialized Care Coordination Grievance Process, and the Notice of Privacy Practices were explained to me, and I have received a copy of each of these.

I have read and understand the terms of this document. I have had an opportunity to ask questions about the contents of this document and have had any questions I may have answered. I acknowledge, consent, and agree to the contents of this document.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Youth Signature (If over 14) Date

_____ _____
Specialized Care Coordinator Signature Date

Circle of Care for Families and Children of Passaic County, Inc.
3 Garret Mountain Plaza, Suite 200 Woodland Park, NJ 07424
973-942-4588

Authorization to Release Protected Health Information

I/We authorize the use/disclosure of information about: _____ (Print Youth's Name)

Youth's Date of Birth: _____

The confidentiality of client records is protected by Federal and State laws and regulations. Release of such information is limited and requires a written release from the service recipient.

1. I hereby authorize Circle of Care to RELEASE, OBTAIN, and DISCUSS my health information with the following (check all that apply – only selected groups will receive information):

☐ The New Jersey Department of Children and Families and the New Jersey Department of Human Services, including all of their component divisions and contracted providers

☐ Any health plan, psychiatrist, psychologist, therapist, crisis response agency, mental or behavioral health care professional, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care or mental health care provider that has provided payment, treatment or services to me or on my behalf

☐ Any state or county entity with past or present involvement in receiving, reviewing, or making determinations regarding Medicaid, New Jersey Family Care, Presumptive Eligibility, Children's System of Care Initiative, Household of One, or related coverage applications for me or on my behalf

Other Partners:

☐ Parent/Guardian(s)_____

☐ Foster Parent(s)/Resource Family _____

☐ School District (please specify district/school)_____

☐ The Family Support Organization of Passaic County (FSO)

☐ Passaic County Juvenile Justice System, including Family Court, Probation and the Juvenile Detention Center

☐ IIC/IIH

☐ BA/ISS

☐ Other _____

☐ Other _____

☐ Other _____

☐ Other _____

☐ Other _____

2. For the purpose of: (Please check all three)

☐ Continued Treatment / Coordination of Care (this includes releasing, obtaining or discussion health information for planning, implementing and monitoring services for the youth and family members and sharing health information, in whole or in part, with the agencies listed above to the extent necessary to develop and implement an individualized service plan).

☐ Legal (including but not limited to court, custody, criminal, etc.)

☐ Insurance/Payment (including but not limited to billing, flex funds, etc.)

☐ Other (specify) ("at the request of the individual" is all that is required) _____

3. Description of health information to be released, obtained or discussed: (Please check one)

☐ Any and all records in the possession of Circle of Care (except as may be changed below)

☐ Records covering the period of time _____ to _____ (except as may be changed below)

☐ Other (specify)_____

Each of the types of health information listed below requires specific authorization for release. For the following types of information, please **initial** your choice for consent:

Substance use records: YES _____ NO _____
HIV/AIDS records: YES_____ NO_____
Mental health records: YES _____ NO _____
Psychotherapy records: YES_____ NO _____

This information may become a part of a participating agency or individual's confidential record. The New Jersey Children's System of Care requires that all participants respect the confidential nature of the records, information, and the proceedings of any meetings. With this release, I/We understand that this information may appear on electronic records.

I/We understand that I/We may refuse to sign this authorization and that refusal to sign will not affect the above-named child from obtaining treatment, payment to be made, or the above-named child's eligibility for benefits or services, however, it may affect determination of appropriate level of care.

I/We understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, if the information pertains to substance use disorder, the recipient may be prohibited from re-disclosing substance abuse information and must be given the notice on prohibition of re-disclosure printed below.

I/We understand that I/We may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided in writing to the Circle of Care's Privacy Officer at the address listed on this form. The revocation will be effective on the date that the Privacy Officer receives the request.

This authorization will automatically expire upon termination of service from Circle of Care or the last day of the month one year from the date of the authorizing signature, whichever is less. I will be given a copy of this authorization for my records.

Signature (or "mark"*) of
Parent or Legal Guardian: _____

Date of Signature: _____

Printed Name of Parent or Legal Guardian*: _____
*(*Legal Guardian: copy of Valid Appointment of Guardianship must be attached).*

Signature (or "mark" *) of Child (if age 14 or older): _____

Date of Signature: _____

If "mark" is provided in place of signature, the "mark" must be witnessed:

Witness Signature (if applicable): _____

Printed Witness Name/Title: _____

Prohibition on Re-Disclosure:
This information has been disclosed to you from substance use disorder records that are protected by New Jersey law (adopting the approach of the federal confidentiality rules, 42 C.F.R. Part 2). The rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see Section 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at Section 2.12(c)(5) and 2.65.