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.

## 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):

Name:_____Relationship: _____

Address/Phone _____ _____

Health Info:_____Payment Info:_____

Name:_____Relationship: _____

Address/Phone _____ _____

Health Info:_____Payment Info:_____

## 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: _____

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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)

☐ New Jersey Counties Juvenile Justice System, including Family Court, Probation and the Juvenile Detention Center

☐ Circle of Care linked services including IIC/IIH/BA/ISS/Mentor/parent coach/outpatient services, partial hospitalization programs, etc.

☐ M&S Psychotherapy and Counseling

☐ Other _____

☐ Other _____

☐ Other _____

☐ Other _____

**2. For the purpose of: (Please check first two lines)**

☐ Treatment, Payment and Health Care Operations (TPO) (this is for all future uses that requires releasing, obtaining or discussing information related to treatment and continuity of care, payment for services or coordination of benefits, and using other health information for Circle of Care's internal operations, including planning, implementing and monitoring services for the youth and family members.)

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

☐ At the Request of the Individual

☐ Other (specify) _____

**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 in 3a below)

☐ Records covering the period of time _____ to _____

☐ Other (specify) _____

**3a. Each of the types of health information listed below requires specific authorization for release. For the following types of information, please put a check in the box of your choice for consent:**

| | | | | | |
|---|---|---|---|---|---|
| Substance Use Records: | YES ☐ | NO ☐ | HIV/AIDS Records: | YES ☐ | NO ☐ |
| Mental Health Records: | YES ☐ | NO ☐ | Psychotherapy Notes: | YES ☐ | NO ☐ |
| Genetic Information: | YES ☐ | NO ☐ | STI/STD Records: | YES ☐ | NO ☐ |
| Substance Use Disorder Counseling Notes: | YES ☐ | NO ☐ | Reproductive Health Records: | YES ☐ | NO ☐ |

**4. Notices/Your Rights**

If you are consenting to the release of substance use disorder records, please note that any consent to release such records for a legal purpose must be a standalone authorization (not combined with a consent for any other purpose). Similarly, any consent to release substance use disorder counseling notes must be a standalone authorization.

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 meeting. With this release, you understand that this information may appear on electronic records.

You understand that in general Circle of Care may not condition its provision of treatment or enrollment in its programs on you signing this authorization. However, in certain cases Circle of Care may require a signed authorization for specific disclosures when it is collecting health information for TPO purposes. If you refuse to sign, we may not be able to bill your health plan or coordinate your treatment with other providers.

You understand that once your information is released, (except as noted below) it may redisclosed by the recipient and no longer protected under HIPAA.

For health information that requires a special authorization (item 3a above), federal and state law as well as 42 CFR Part prohibits the unauthorized use or disclosure of this information. This would mean that unless the law or regulations permit a disclosure, your consent would be required for any further disclosure. In the special case for substance use disorder records protected by 42 CFR Part 2, you may authorize their disclosure (and redisclosure) for all future TPO purposes. If so, your information may no longer be protected by 42 CFR Part 2, but by HIPAA.

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 remain in effect until the youth transitions from CMO, unless earlier revoked or terminated as referenced above. This authorization will automatically expire upon termination of service from Circle of Care. If you wish to receive a copy of this authorization, you have the right to request one be provided to you.

Under New Jersey law, minors have a right to independently consent to certain medical treatment or counseling and to control whether and to whom certain of their information is disclosed. For outpatient mental health services, the age of majority is 16 years old.

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: _____