



**family
connections**

**NJ4S
ESSEX**

Authorization to Disclose Protected Health Information

Client Name: _____

Date: _____

By signing this form, I authorize Family Connections and

(Name of School)

to share the following information regarding the above-named client's enrollment in the NJ4S program:

- Attendance in NJ4S Services.
- Enrollment Status within the NJ4S Program.
- Reason for Discharge from NJ4S Program.
- NJ4S' Discharge Recommendations.

The purpose of this authorization is to allow these parties to coordinate care, as well as provide referrals and academic support.

I understand that medical records are protected under federal and state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164 and cannot be disclosed without written authorization of the client (or parent or guardian if client is a minor) unless otherwise provided for in those laws and/or regulations. In some cases, federal law, e.g., HIPAA, does not prevent the persons or entities named above from redisclosing the information.

I further understand that the information to be shared by Family Connections is limited to the scope outlined above. Should the school request or require additional information, such as diagnosis, records, or other details regarding treatment, a new Release of Information Authorization will need to be signed specifically requesting that information.

This authorization will remain in effect for one year from the date of my signature unless it is revoked sooner. I understand that I may revoke this authorization at any time in writing except to the extent that

action has been taken in reliance on it. If I wish to rescind this authorization prior to its expiration, I may submit a request in writing to Family Connections.

Acknowledgement and Signature

I acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

I have been provided with a copy of this form. I understand that I may also request Family Connections to provide me with a copy.

Signature

Date

Name of Person Signing

Relationship to Client

Client Signature

Date

Print Client Name