RUTGERS HEALTH

Collaborative Behavioral Healthcare Project - Essex County Hub
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Rutgers University Health Care in Collaboration with Essex County Primary Care Providers
RECORDS RELEASE AUTHORIZATION

I, _____, hereby give permission to
(Parent's/ Legal Guardian's name)

my Primary Care Provider _____ to release information from
(Primary Care Provider's name)

the files of _____, my son/daughter.
(Child's name and DOB)

Information to be released are gathered from:

- Psychiatric screening tools, including the **Pediatric Symptom Checklist-17 (PSC-17), CRAFFT Screening Interview, and/or the Adverse Child Experience (ACE) Questionnaire,** which were administered to my child at my Primary Care Provider's office

- **Telemedicine and/or face-to-face evaluation and consultation by a psychiatrist**. Consultations and evaluations may include pertinent medical information, including but not limited to, current and past medical diagnoses and medication history

This information is to be released to the Rutgers Health Collaborative Behavioral Healthcare Project (Essex County Hub).

The purpose or need for such disclosure is:

- **To generate a psychiatric report,** which will be created by the Essex County Hub and returned to the Primary Care Provider within 2 weeks
- **To provide consultation services**
- **To connect to and/or provide patients with appropriate behavioral healthcare services**

I have been provided with the option to utilize face-to-face consultation at a later date. However, I am agreeing to participate in Telepsychiatry, from a location that will be disclosed to me, by placing my initials here _____.

I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).

This consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon.

_____
Signature of Patient (Patient must sign for himself/herself if 14 years of age or older) Date: _____

_____
Signature of Parent, Guardian or Authorized Representative in lieu of Patient Date: _____

_____ Date: _____
Signature of Witness

The within information is disclosed to you from records whose confidentiality is protected by federal law, Federal Regulations (42 CFR-Part 2 and 42 CFR-Parts 160 & 164) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains or, as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.