MIDDLESEX COUNTY

MENTAL HEALTH DIVERSION PROGRAM RELEASE

Release of Psychiatric, Psychological, Mental Health Treatment, Substance Use, Addiction, Medical and/or Hospital Information and Records, hereinafter "Release"

Please have the defendant read each item listed below, initial page 1, and sign and date page 2.

I, _____, _____, do
(Name) (Date of Birth)

hereby authorize any psychiatrist, psychologist, mental health provider, substance use or addiction provider, physician, hospital, medical attendant, medical provider, or any others to whom this authorization is directed, to disclose any and all information and/or opinions, orally or in writing, regarding my history, diagnosis and/or treatment of any psychiatric condition(s), medical condition(s), mental illness, or drug/alcohol use which any representative of the Middlesex County Mental Health Diversion Program ("Program") may request.

I acknowledge and am aware that both the State of New Jersey and the United States government have statutory and other privileges accorded to confidential communications between a patient and a licensed physician, psychologist and/or other staff involved in providing health care and that my signing this Release waives these privileges.

I acknowledge and am aware that if my medical records contain information regarding sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV), this information will be disclosed as part of the medical record to the person authorized to receive records. By initializing this document, I am providing written authorization to disclosure of that information.

I acknowledge and am aware that the uses and disclosures of my health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by privacy and confidentiality laws but shall not be distributed to persons not associated with the Program. Possible persons/entities associated with the Program include but are not limited to: Superior Court Judges, Public Defender's Office, private defense attorneys, the MC Probation Department, Middlesex County Jail staff, and community and private Mental Health program providers and representatives and authorized designees of same.

I acknowledge and am aware that this information is to be used solely for acceptance into and continued participation in the Program. If I am not accepted or am terminated from the Program, any information including any statements made by me or evidence derived therefrom shall not be used in any traditional criminal proceeding against me, unless said records are obtained by separate release or court order.

I acknowledge and am aware that I may revoke this Release at any time by sending written notice to the Program and any or all of the providers who have released information to the Program, except to the extent that the Program or any or all of said providers has already taken action in reliance on it. I understand that revocation of any release will result in immediate termination from the program. If not previously revoked, this release will terminate in **five (5) years** from the date of execution.

I acknowledge and am aware that participation in the Program is conditioned upon signing this Release. I understand I will no longer be eligible for the program if I do not sign or I revoke this Release.

Any photocopy of this authorization shall have the same force and effect as the original.

Defendant's Signature: _____ Date: _____

Defense Counsel's Name: _____

Signature: _____ Date: _____

Assistant Prosecutor's Name: _____

Signature: _____ Date: _____