Atlantic County Prosecutor's Office

Veteran's Diversion Program

RELEASE OF PSYCHIATRIC, MENTAL HEALTH TREATMENT, SUBSTANCE ABUSE, ADDICTION, MEDICAL AND/OR HOSPITAL INFORMATION AND RECORDS, HEREINAFTER "RELEASE"

**** All Forms Must Be Filled Out Completely Before Consideration For The Program.***
**** Please have the defendant read each item listed below, initial pg. 1, and sign and date pg. 2.***

I, _____ (name, date of birth, S.S. #), do hereby authorize any psychiatrist, psychologist, mental health provider, substance abuse 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, drug abuse, or alcoholism, which any representative of the Atlantic County Prosecutor's Office Veteran's Diversion Program ("Program") may request.

I acknowledge and I 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 I 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 paragraph, I am providing written authorization to disclosure of that information.

I acknowledge and I am aware that the uses and disclosures of my health information authorized by this document may be subject to re-disclosure 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 person/entities associated with the Program include but are not limited to: Superior Court Judges, the Office of the Public Defender, private defense attorneys, the U.S Attorney's Office, law enforcement, the

probation department, the Atlantic County Justice Facility, community mental health representatives, Veteran's Mentor Coordinator, Veteran's Mentors, Veteran's Administration, and community mental health program providers.

I acknowledge and I 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 I 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 I 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 consent will terminate in **three (3) years** from the date of execution.

I acknowledge and I 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 Release shall have the same force and effect as the original.

_____ _____
Defendant's Signature Date

Defendant's Phone Number: _____

_____ _____
Signature of Defendant's Guardian (if app.) Date

_____ _____
Defense Counsel Signature Date

_____ _____
Assistant Prosecutor's Signature Date