SALEM COUNTY PROSECUTOR'S OFFICE
VETERANS DIVERSION PROGRAM

Release of Psychiatric, Psychological, 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 Page 1 and sign and date Page 2.

I, ____________________________, _____________, _____________, do hereby authorize any
Defendant Name Date of Birth SS #

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 Salem County Prosecutor's Office Veterans 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 diseases, 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 the disclosure of that information.

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Initials

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, the Public Defender's Office, Private Defense Attorneys, the U.S. Attorney's Office, Law Enforcement, the Probation Department, Salem County Correctional

Facility, Community Mental Health representatives, Veteran's Mentor Coordinator, Veteran's Mentors, Veteran's Administration and Community Mental Health program providers.

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 consent will terminate in **three (3) 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 force and effect as the original.

Defendant's Signature: _________________________________ Date: ______________________

OR

Signature of Defendant's Legal Guardian: _________________________ Date: ________________

Defense Counsel's Name: ____

Signature: ______________________________ Date: _______________

Assistant Prosecutor's Name: ____

Signature:_______________________________ Date: _______________

Defendant's Phone Number(s): Home _____________ Work _____________ Cell ____________