Bergen County Prosecutor’s Office
Veterans Diversion Program Release

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. ***

The defendant must read this entire form, initial page 1, and sign and date page 2.

I, ______________________________________, ________________, ______________________, do hereby
(name of defendant) (date of birth) (social security number)
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 records, 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 Bergen County Prosecutor's Office Veterans Diversion Program ("the 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 initialing this page, 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 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 persons/entities associated with the Program include but are not limited to Superior Court Judges, the Public Defender’s Office, Private Defense Attorneys, Law Enforcement, the Probation Department, Bergen County Jail, Community Mental Health representatives, Veterans Mentor Coordinators, Veterans Mentors, Veterans Administration and Community Mental Health program providers.

Defendant’s initials: ___________

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 two (2) 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 Name: ____

Defendant's Signature: ____ Date: ____________

Defendant's Phone Number(s):

Home: ___________________________

Work: ___________________________

Cell: _____________________________

Defense Counsel's Name: ____

Defense Counsel's Signature: ____ Date: ____________