PROB 15 (REV. 02/2026) UNITED STATES DISTRICT COURT

INSTRUCTIONS TO PERSONS REFERRED TO THE U.S. PROBATION OFFICE

Following a guilty plea or guilty verdict, the court will set a schedule for sentencing that includes the preparation of the presentence investigation report, which will aid the court in determining an appropriate sentence.

To assist in the presentence investigation, please complete the attached Personal Questionnaire, the Net Worth and Monthly Cash Flow statements, and sign the Declaration of Net Worth and Cash Flow statements.

Supporting documentation must be provided for all reported financial information.

Please also sign all attached authorization to release confidential information forms.

All required documentation can be submitted to the following email address:
njp_Presentence@njp.uscourts.gov

Documents can be submitted in advance of the guilty plea and/or the presentence interview. The presentence interview must occur within 14 days of the plea or guilty verdict, in compliance with the Standing Order of the Court, amended October 8, 2020.

Please also provide copies of the following documents, as applicable, no later than the time of the presentence interview:

- Birth certificate
- Social Security card
- Driver's license or state issued photo identification
- School diplomas and professional certificates/licenses
- Proof of residence (mortgage commitment or lease and rental receipts)
- Military discharge certificate
- Marriage certificate and/or divorce decree
- Child support orders
- Bankruptcy petitions/Bankruptcy discharge papers
- Income tax returns, including all schedules, statements, and W-2 forms for the last 3 years
- Employment verification (pay stubs)
- Immigration documentation (legal permanent resident or naturalization certificate)
- Passports
- Medical records/reports and a list of all prescribed medications
- Department of Human Services/Board of Social Services/public assistance records

If you are not contacted by a U.S. Probation Officer regarding the scheduling of the presentence interview within three days of the guilty plea or jury verdict, please advise your attorney and contact one of the following Supervisory U.S. Probation Officers based on the courthouse location where your case is assigned:

Newark: Donald L. Martenz, Jr. - (973) 223-0236
Natalie Shreve - (973) 936-4852

Trenton: Danielle K. Vargas – (973) 647-0299

Camden: Matthew F. Hulick - (856) 305-7994

Personal Questionnaire - Presentence Investigation

Please complete all sections of this form and return it to the assigned probation officer.

This form can also be completed in advance of the guilty plea and submitted via email to: NJP_Presentence@njp.uscourts.gov

Fillable copies of presentence forms can be found at: https://www.njp.uscourts.gov

Date of interview: _____

Attorney present? Yes ☐ No ☐

Interpreter: _____

Collateral contact name and number: (1) _____

Relationship to you: _____

Collateral contact name and number: (2) _____

Relationship to you: _____

Form 1 Revised
Rev. 02/2026

Face Sheet Data

Court Name:	True Name:
Docket No.:	USPO:
Assistant U.S. Attorney: (Name and Telephone)	Defense Counsel: (Name and Telephone)

DEFENDANT'S IDENTIFICATION

Alias, other names used (maiden), nicknames:

Date of Birth:	Age:	Sex at Birth:	City, State, Country of Birth:	SSN:

Race: (Hispanic, Non-Hispanic, African-American, Asian, White, Other)	Hair Color:	Eye Color:	Height:	Weight:

Country of Citizenship:	U.S. Immigration Status: (naturalized citizen, legal resident, no legal status)

Current Address: _____

_____

Phone No.: _____ Email: _____

Time at this residence: _____

Current Occupants/Animals at Residence:

_____

If in custody, do you plan to return to this address? If not, where will you live?

_____

Where else have you lived? (city, state, and years at each location):

_____

Are you in custody now? Yes ☐ No ☐ Are you on bail now? Yes ☐ No ☐

In Custody Since: _____ Date of release: _____

Custody Location: _____ Name of supervising Pretrial Services Officer:

_____

Parents and Siblings

List your biological parents first. If you were raised by anyone other than your biological parents, please add the other parents' names below the space for Mother and Father. After your parents, list all your siblings, living and deceased.

Name	Relation-ship	Age	Address / Telephone #	Occupation	Criminal Record
	Mother				Y☐ N☐
	Father				Y☐ N☐
					Y☐ N☐
					Y☐ N☐
					Y☐ N☐
					Y☐ N☐
					Y☐ N☐
					Y☐ N☐

Who of the listed family members have health problems or long-term serious injury or illness? If any, explain.

Who raised you? Explain.

What kind of neighborhood did you grow up in? Explain.

Were there financial problems in your childhood home? If yes, explain.

Was there any drug use or alcohol abuse in your childhood home? If yes, explain.

Was there any violence and/or physical/mental abuse in your childhood home? If yes, explain.

Which family members are you closest with?
Which family members know about this federal case?

Marital History

Married? Yes ☐ No ☐

Are you currently in a non-marital, committed relationship? Yes ☐ No ☐

Have you been married previously? Yes ☐ No ☐

Name	Age	Place and Date(s) of Marriage Court and Date of Divorce	Occupation and Address/ Telephone #	Criminal Record
Current Spouse/ Domestic Partner				Y ☐ N ☐
Prior Spouse/ Domestic Partner				Y ☐ N ☐
				Y ☐ N ☐
				Y ☐ N ☐

Children

Name	Age	Name of Other Parent	Who has custody?	Occupation and Address/ Telephone #	Is child support ordered?
					Y ☐ N ☐
					Y ☐ N ☐
					Y ☐ N ☐
					Y ☐ N ☐
					Y ☐ N ☐
					Y ☐ N ☐

Describe your relationship with your child(ren).

Did you previously, or do you currently, help raise any other children? If yes, explain.

List any health problems, substance abuse, or any other significant information regarding your spouse, domestic partner, and/or children.

If you are incarcerated, or will likely become incarcerated, who will care for your children?

Physical Condition

Do you have a Primary Care Physician (regular doctor)? Yes ☐ No ☐

Name of Primary Care Physician	Address	Phone Number

Do you have any current health problems or concerns? Yes ☐ No ☐

Explain your health problem(s), including approximate date the problem started, any diagnoses, and treatment.

Do any of your current health issues limit your activity or your ability to work? Yes ☐ No ☐ If yes, explain.

Do you have any specialty doctors? (Example: cardiologist, oncologist, etc.) Yes ☐ No ☐

Name of Specialist	Address	Phone Number	Illness Treated and Date(s)

Are you currently taking any prescribed medications? Yes ☐ No ☐

Name of Medication/Dosage	Reason for Medication	Prescribing Doctor and Address

List any allergies to food or medication.

Have you ever been hospitalized? Yes ☐ No ☐

Date(s)	Name of Hospital and Address	Reason (ex. surgeries, gunshot wounds, stab wounds, pins/screws in your body, etc.)

List all tattoos and noticeable scars

Description	Location on your body	Meaning

Have you ever been affiliated with any street gang, outlaw motorcycle group, or other organization? Explain.
If so, are any of the tattoos related to this group(s)?

Mental Health

Have you ever been treated for or diagnosed with a mental health issue? Yes ☐ No ☐
If so, check all that apply.

- ☐ Anger issues
- ☐ Anxiety
- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Mood Swings
- ☐ Obsessive Compulsive Disorder
- ☐ Other: _____
- ☐ Other Learning Disabilities
- ☐ Psychiatric hold
- ☐ Schizophrenia
- ☐ Self Mutilation
- ☐ Sexual Abuse
- ☐ Sex Offender Treatment
- ☐ Suicidal attempts
- ☐ Suicidal thoughts

Explain.

Are you currently seeing, or have you previously seen, a Mental Health Provider (example: counselor, therapist, psychiatrist)? Yes ☐ No ☐

Provider Name and Address	Type and Frequency of Treatment (inpatient, outpatient, individual, group)	Dates and Reason for Treatment	Successfully completed?
			Y ☐ N ☐
			Y ☐ N ☐
			Y ☐ N ☐

Are you currently taking any prescribed medications for mental health reasons? Yes ☐ No ☐

Name of Medication/Dosage	Reason for Medication	Prescribing Doctor and Address

Have you ever participated in any anger management counseling or domestic violence counseling? Yes ☐ No ☐
If so, was it court-ordered? Explain.

Do you believe you would benefit from mental health counseling now? Explain. Yes ☐ No ☐

Does anyone in your immediate family have any mental illness or developmental disabilities? Explain. Yes ☐ No ☐

Do you gamble in the streets or online, in casinos, engage in sports betting, or play the lottery? Explain. Yes ☐ No ☐

How much have you won? How much have you lost? When and where did these occur?

Do you think your gambling is a problem? Do your family members think your gambling is a problem? Explain. Yes ☐ No ☐

Do any family members have a gambling history/addiction? Explain. Yes ☐ No ☐

Substance Use			
Drug	**Age at first use**	**Frequency (example: everyday, twice per week, once per month, etc.)**	**Date of last use**
Alcohol			
Marijuana			
Cocaine			
Crack (Cocaine base)			
Heroin			
Methamphetamine			
Ecstasy (MDMA or Molly)			
Fetanyl			
LSD (Acid)			
Benzodiazepines (eg. Xanax, Valium)			
Synthetic cannabinoids (eg. Spice, K2)			
Medication not prescribed to you:			
Other drugs (list drug name):			

What drug has caused the most problems in your life? Explain why.

What is your first drug of choice?

Have you ever used more drugs than you planned? If yes, explain. Yes ☐ No ☐

Have you ever used drugs while incarcerated? If yes, explain. Yes ☐ No ☐

Have you ever used drugs while on probation or parole? If yes, explain. Yes ☐ No ☐

Are you currently in or have you ever participated in a substance abuse treatment program (example: inpatient, outpatient, detoxification, NA/AA)? Yes ☐ No ☐

Provider Name and Address	Type of Treatment (inpatient, outpatient, individual, group)	Dates and Reason for Treatment	Successfully completed?
			Y ☐ N ☐
			Y ☐ N ☐
			Y ☐ N ☐
			Y ☐ N ☐

What is the longest period you remained drug/alcohol free? Please provide dates.

Have you ever relapsed after being sober? If yes, explain why. Yes ☐ No ☐

Have you ever been arrested for driving under the influence? If yes, when and where? Yes ☐ No ☐

What were the negative consequences related to your drug/alcohol use (eg: accidents, injuries, job problems, relationship problems, school problems, legal problems)?

Does anyone in your family have a drug/alcohol problem? If yes, explain. Yes ☐ No ☐

Do you believe you would benefit from drug/alcohol treatment? Why or why not? Yes ☐ No ☐

Education				
Name and Address of School	Dates attended	Last grade completed? Provide transcripts/diploma if diploma, degree, or certificate received.	GPA	Reason for leaving: (eg. graduated, expelled, incarcerated, withdrew)

Do you have a GED? Yes ☐ No ☐ If yes, date received:

If yes, in what state did you earn the GED?

What is your primary/native language? What other languages do you speak?

Can you read and write English? Yes ☐ No ☐

Did you have behavior problems in school? If yes, explain. Yes ☐ No ☐

Were you ever suspended from school? If yes, explain. Yes ☐ No ☐

List any grades you repeated in school.

Were you in special education classes or had an Individualized Education Plan (IEP)? If yes, explain. Yes ☐ No ☐

Do or did you have a learning disability? If yes, explain. Yes ☐ No ☐

Did you participate in any extra-curricular activities in school (eg. sports, musical groups, clubs, etc.)? Yes ☐ No ☐
If yes, explain.

Do you plan to continue your education? If yes, explain. Yes ☐ No ☐

Employment

Please list jobs and periods of unemployment for the past 10 years. Start with your present position and work backward. If you have a resume, please attach.

Employer Name and Address	Start Date	End Date	Position / Type of Work	Salary / Hourly Wage	Reason for Leaving

Is your current employer aware of your arrest in the instant offense? If no, explain. Yes ☐ No ☐

List occupational skills, licenses, and certifications.

Have you ever applied for or received disability benefits for any reason? If yes, explain. Yes ☐ No ☐

How did you support yourself during periods of unemployment?

What are your future employment goals?

Military

List dates of military service, branch, commendations, deployments, duty station(s), and type of discharge.
Please provide DD214.

Prior Record

Are you currently on probation or parole? If yes, explain why and include your reporting schedule. Yes ☐ No ☐

If yes, Name of Probation/Parole Officer: _____ Phone Number: _____

Were you previously under any term of probation or parole? If so, when? Yes ☐ No ☐

Name of Probation/Parole Officer: _____

Phone Number: _____

Have you violated any term of probation, parole, or pretrial release? If so, explain. Yes ☐ No ☐

Have you ever been cited or arrested as a juvenile? If so, explain. Yes ☐ No ☐

Driver's License

List all states/countries where you have held a driver's license.

State	License Number	Status of License	Prior Suspensions

Acceptance of Responsibility Statement

Please explain, in your own words, using the space below, why you committed the offense.

You may want to think about the following questions as you write your response:

- What led you to get involved in the offense?
- What did you gain from the offense, if anything?
- How has your behavior affected your family and friends?
- What could you have done differently to prevent this from happening?
- What will you do differently in the future, so this does not happen again?
- Is there anything else you want the judge to know about you?

You may want to speak with your attorney before completing this section.

I declare the above information is true and correct.

Completed by: _____ Date: _____

Defendant's Signature: _____

REQUEST FOR NET WORTH STATEMENT FINANCIAL RECORDS

DEFENDANT'S FULL NAME	DOCKET NUMBER

All entries on the Net Worth Statement must be accompanied by supporting documentation. Provide the probation officer with all records listed below that are applicable to your financial statements, along with your completed Net Worth Statement by the close of business _____ .

ASSETS

Section A – Bank Accounts

- Most recent bank account statements (e.g., checking, savings, credit union, money market, brokerage, Certificate of Deposit, IRA, ROTH IRA, KEOGH, 401K, or thrift savings account) for a three-month period.

Section B – Securities

- Most recent securities account statements (e.g., brokerage, annuities, life insurance) for a three-month period.

Section C – Notes & Accounts Receivable

- Copy of signed note receivable.

Section D – Life Insurance

- Copy of all life insurance policies (e.g., whole life, variable life, term).

Section E – Safe Deposit Boxes or Storage Facilities

- Copy of most recent rental invoice for all safe deposit boxes or storage facility rentals within the past year, including receipts or verification of content value.

Section F – Motor Vehicles

- Copy of vehicle registration and title for all vehicles owned or leased.

Section G – Real Estate

- Copy of purchase agreement, deeds, and escrow statement for all real property.

Section H – Mortgage Loans Owed To You

- Copy of the sales agreement and escrow statement for all real property.

Section I – Other Assets

- Copy of purchase invoice and appraisal (if already previously obtained), and documentation to verify the fair market value of the asset.

Section J – Anticipated Assets

- Copy of documentation to verify future receipt of anticipated asset, (e.g., claim or lawsuit filings, profit sharing plan and current statement, pension plan and current statement, inheritance documents, copy of all trusts, trust income tax returns), and most recent accounting reflecting the value of your interest and income from the trust.

Section K – Business Holdings

- In addition to providing the information requested in Section K and completing Section N, provide copies of all income tax returns for each business you had an ownership interest in (e.g., shareholder, partner, proprietor) or an affiliation with (e.g., officer, director, board member, agent, associate) within the last five years. Also provide all financial statements for each business, prepared by you or your accountant, within the past five years.

Business Accounts Receivable

- Copy of current month's billing statements that verify business accounts receivable.

Business Accounts Payable

- Copy of current month's vendor invoices that verify business accounts payable.

Section L – Income Tax Returns

- Copy of the five most recent years' income tax returns filed for: Individual (Form 1040), Partnership (Form 1065), Corporation (Form 1120), S Corporation (Form 1120S), and Limited Liability Company (Form 1065). Be sure to include all related schedules and forms. Provide a written explanation for any returns not filed.

Section M – Transfer of Assets

- Copy of the bill of sale, documentation of funds received from sale (e.g., a personal or business check, cashiers check or money order), copy of vehicle registration and title of sold vehicle, and escrow closing statements for any real estate sold since the date of your arrest.

Section N – Names of Shareholders or Partners

- Copy of Articles of Incorporation for all corporations you own or have an interest in. Copy of partnership agreement for all partnerships you have an ownership interest in.

Section O – Assets You Will Liquidate

- Assets available for payment of criminal monetary penalties

REQUEST FOR NET WORTH STATEMENT FINANCIAL RECORDS (cont.)

LIABILITIES

Section A – Charge Accounts	**OTHER RECORDS REQUESTED**
♦ Copy of most current billing statement for all charge accounts (e.g., credit cards, revolving charge cards, and department store cards) and lines of credit (e.g., bank line of credit). **Section B – Other Debts** ♦ Copy of all notes payable, mortgage loans, current statement of delinquent taxes due, and statements documenting child support/ alimony obligations and payment history. **Section C – Party to Civil Suit** ♦ Copy of all civil suit filings and judgments. **Section D – Bankruptcy Filings** ♦ Copy of all bankruptcy filings including petition, financial statements submitted, final judgment and order of discharge.	

ADDITIONAL INSTRUCTIONS:

A personal interview has been scheduled for you with:

_____ on _____
U.S. Probation Officer Date

at _____ Office Location _____
Time

Telephone _____

Last Name	First Name	Middle Name	Social Security Number

Instructions for Completing Net Worth Statement

Having been convicted in the United States District Court, you are required to prepare and file with the probation officer an affidavit fully describing your financial resources, including a complete listing of all assets you own or control as of this date and any assets you have transferred or sold since your arrest. Your Net Worth Statement should include assets or debts that are yours alone (I-Individual), assets or debts that are jointly (J-Joint) held by you and a spouse or significant other, assets or debts that are held by a spouse or significant other (S-Spouse or Significant Other) that you enjoy the benefits of or make occasional contributions toward, and assets or debts that are held by a dependent (D-Dependent) that you enjoy the benefits of or make occasional contributions toward.

If you are placed on probation or supervised release (or other types of supervision), you may be periodically required to provide updated information fully describing your financial resources and those of your dependents, as described above, to keep a probation officer informed concerning compliance with any condition of supervision, including the payment of any criminal monetary penalties imposed by the court (see 18 U.S.C. § 3603).

Please complete the Net Worth Statement in its entirety. You must answer "None" to any item that is not applicable to your financial condition. Attach additional pages if you need more space for any item. All entries must be accompanied by supporting documentation (see Request for Net Worth Statement Financial Records (Prob. 48A)). Initial and date each page (including any attached pages). Also, sign, date, and attach the Declaration of Defendant or Offender Net Worth & Cash Flow Statements (Prob. 48D).

Last Name -

NET WORTH STATEMENT

NOTE: I = Individual J = Joint S = Spouse/Significant Other D = Dependent

ASSETS

Section A

BANK ACCOUNTS (Include all personal and businesses checking and savings accounts, credit unions, money markets, certificates of deposit, IRA and KEOGH accounts, ROTH IRA's, Thrift Savings, 401K, etc.)

I/J S/D	Name of Institution	Address	Type of Account	Account Number	Personal or Commercial	Balance

Section B

SECURITIES (Include all stocks in public corporations, stocks in businesses you own or have an interest in, bonds, mutual funds, U.S. Government securities, etc.)

I/J S/D	Name and Kind of Security	Location of Security	Number of Units	Fair Market Value

Section C

MONEY OWED TO YOU BY OTHERS (Include all money owed to you by any person or entity.)

I/J S/D	Name and Address of Debtor	Amount Owed to You	Reason Owed to You	Date Money Loaned	Relationship to Debtor (if any)	Monthly Payment or Date Full Payment Expected	Is Debt Collectible ?

Initials _____ Date _____

Last Name -

Section D

LIFE INSURANCE (Include type of policy [whole life, variable, or term], face amount [the stated amount of coverage] and cash surrender value [the value of the investment portion of a whole life or variable policy.])

I/J S/D	Name and Address of Company and Name of Beneficiary	Policy Number	Type of Policy	Face Amount	Cash Surrender Value	Amount Borrowed	Amount You Can Borrow

Section E

SAFE DEPOSIT BOXES OR STORAGE SPACE FACILITY (Include all safe deposit boxes or storage space you rent or places you have access to in which others are holding assets or items belonging to you.)

I/J S/D	Name and Address of Box or Facility Location	Box Number or Space	Contents	Fair Market Value

Section F

MOTOR VEHICLES (Include all cars, trucks, mobile homes, motorcycles, all terrain vehicles, boats, airplanes, etc.)

I/J S/D	Year, Make & License Number/Vehicle Identification Number	Mileage	Loan/Lease Balance (if any)	Date Loan/Lease Will be Paid Off or Ends	Monthly Payment	Fair Market Value

Section G

REAL ESTATE (Include property, parcels, lots, timeshares, and developed land with buildings.)

I/J S/D	Real Estate Address (include county and state)/ Mortgage Company or Lien Holder	Purchase Date	Purchase Price	Mortgage Balance (if any)	Date Mortgage Will be Paid Off	Monthly Payment	Fair Market Value

Section H

MORTGAGE LOANS OWED TO YOU (Include name, address, and relationship [if any] to the mortgagee [the party that bought the real estate you sold and is making payments to you].)

I/J S/D	Mortgagee (name & address)/ Relationship to Mortgagee	Mortgage Balance	Date Mortgage Will be Paid Off	Balloon Payment? If Yes, Date?	Monthly Payment	Is Debt Collectible?

Last Name -

Section I

OTHER ASSETS (Include any cash on hand, jewelry, art, paintings, coin collections, stamp collections, musical instruments, collectibles, antiques, home furnishings, copyrights, patents, etc.)

I/J S/D	Description	Loan Balance (if any)	Date Loan Will be Paid Off	Monthly Payment	Where is Asset Located?	Fair Market Value

Section J

ANTICIPATED ASSETS (Include any assets you expect to receive or control from lawsuits for compensation or damages, profit sharing, pension plans, inheritance, wills, or as an executor or administrator of any succession or estate.)

I/J S/D	Amount Received or Expected to Receive	Date Expected to Receive	Reason You Expect This	Name and Address of Person or Company That Can Verify This (e.g., attorney, financial institution, executor)

TRUST ASSETS (Include all trusts in which you are a grantor or donor [the person who establishes the trust], the trustee or fiduciary [who controls the trust assets and income or the beneficiary who has or will receive benefits from the trust].)

I/J S/D	Name of Trust/ Taxpayer ID#	Value of Trust	Your Annual Income From Trust	Your Interest in Trust Assets

Section K

BUSINESS HOLDINGS (Include all businesses in which you have an ownership interest or with which you had an affiliation within the last three years; e.g., self-employed sole proprietor, officer, shareholder, board member, partner, associate, etc.) Complete Section N (attach additional pages, if necessary).

I/J S/D	Name and Address of Business/ Taxpayer I.D.#	Type of Business Entity	Industry of Business	Date Business Started	Capital Investment to Start	Your Ownership Interest Percentage	Sale Price or Fair Market Value of Your Interest

Last Name -

Section L

INCOME TAX RETURNS

Type of Income Tax Return Filed	Last Filing Year	Years of Last 5 Income Tax Returns You Will Submit to the Probation Officer
Individual (Form 1040)		
Partnership/Limited Liability Company (Form 1065)		
Corporation (Form 1120)		
S Corporation (Form 1120S)		

Section M

TRANSFER OF ASSETS (Include any assets you have transferred or sold since the date of your arrest with a cost or fair market value of more than $1,000.00. Also list any assets that someone else is holding on your behalf.)

I/J S/D	Description of Asset/ Reason Transferred/Sold	Date of Transfer/Sale	Original Cost	Amount You Received, if Any	Name of Purchaser or Person Holding the Asset	Sale Price or Fair Market Value at Transfer

Section N

NAMES OF SHAREHOLDERS OR PARTNERS (Include all shareholders, officers, and/or partners, indicating each respective ownership interest.)

Name of Business	Names of Shareholders/Partners	Ownership Interest Percentage

Last Name -

Section O

ASSETS YOU WILL LIQUIDATE (Include all assets you intend to liquidate to satisfy any criminal monetary penalties that may be imposed.)

Asset Description	Estimated Value of Asset	Date You Will Liquidate	Current Location of Asset (if real property, county and state)

Section P

PROSPECT OF INCREASE IN ASSETS (Give a general statement of the prospective increase of the value of any asset you own.)

Last Name -

LIABILITIES

Section A

CHARGE ACCOUNTS AND LINES OF CREDIT (Include all bank credit cards, lines of credit, revolving charge accounts, etc.)

I/J S/D	Type of Account or Card	Name and Address of Creditor	Credit Limit	Amount Owed	Credit Available	Minimum Monthly Payment

Section B

OTHER DEBTS (Include mortgage loans, notes payable, delinquent taxes, and child support.)

I/J S/D	Owed To	Address	Relationship (if any)	Amount Owed	Reason Owed	Monthly Payment

Section C

PARTY TO CIVIL SUIT (Include any civil lawsuits you have ever been a party to.)

I/J S/D	Name of Plaintiff in the Case	Court of Jurisdiction and County	Case Number	Date of Suit Filed	Date of Judgment	Judgment Amount/ Unpaid Balance

Section D

BANKRUPTCY FILINGS (Include information requested for any Chapter 7, 11, or 13 bankruptcy filings you have ever been a party to as an individual or as a business entity.

I/J S/D	Type of Bankruptcy (Voluntary or Involuntary)/ Name and Address of Trustee	Bankruptcy Case Number	Bankruptcy Court of Jurisdiction	County and State of Discharge	Date Filed	Date of Discharge

Signature _____ Date _____

REQUEST FOR MONTHLY CASH FLOW STATEMENT FINANCIAL RECORDS

DEFENDANT'S FULL NAME	DOCKET NUMBER

All entries on the Cash Flow Statement must be accompanied by supporting documentation. Provide the probation officer with all records listed below are applicable to your financial statements, along with your completed Cash Flow Statement by the close of business _____ .

MONTHLY CASH INFLOWS

Salary/Wages

- ✦ Copy of all W-2 forms submitted with the prior year income tax return. Copy of all pay stubs for the most recent one-month period.

Cash Advances

- ✦ Copy of all pay stubs documenting cash advances.

Cash Bonuses

- ✦ Copy of all pay stubs documenting cash bonuses, and copy of related 1099

Commissions

- ✦ Copy of all 1099 forms submitted with the prior year income tax return.

Business Income

- ✦ Copy of the past six monthly financial statements of all businesses owned

Interest/Dividends

- ✦ Copy of most recent earnings statement from a financial institution (e.g.,

Rental Income

- ✦ Copy of lease rental agreement, copy of monthly rental check received, and

Trust Income

- ✦ Copy of the monthly trust income check, copy of the trust agreement, and a

Alimony/Child Support

- ✦ Copy of divorce decree, copy of payments received, and statements

Social Security

- ✦ Copy of most recent Social Security check and most recent benefits

Other Government Benefits

- ✦ Copy of most recent government subsidy check (e.g., unemployment

Pensions/Annuities

- ✦ Copy of pension/annuity check, copy of most recent pension plan activity

Allowances (housing, auto, travel)

- ✦ Copy of related pay stub, 1099 form for prior year, and possibly a letter

Gratuities/Tips

- ✦ Copy of current month's pay stubs, letter from employer estimating monthly gratuities earned, and W-2 form for the prior year.

Spouse (Significant Other's) Salary/Wages

- ✦ Copy of all W-2 forms submitted with the prior year income tax return. Copy of all pay stubs for the most recent one-month period.

Other Joint Spousal Income

- ✦ Documentation verifying any monthly income jointly earned with the spouse or significant other, (e.g., income from the spouse or significant other or income from a business owned or controlled by the spouse or significant other, that the offender has a joint ownership interest in, or controls).

Income of Others in the Home

- ✦ Verification of the monthly earnings of all others living in the offender's household (e.g., all pay stubs for the prior month, W-2 forms, and 1099 forms for the prior year), paid receipts or canceled checks for necessary monthly household expenditures (e.g., for food, room rental, telephone, transportation, etc.) actually paid by this person on behalf of the offender.

Gifts From Family

- ✦ A signed and dated statement from the family member who gave gifts to the offender during the month, listing the amounts, dates and reasons given, and a copy of the check received, if any.

Gifts From Others

- ✦ A signed and dated statement from the person(s) who gave gifts to the offender during the month, listing the amounts, dates and reasons given, and a copy of the check received, if any. Gifts over a certain amount require tax forms declaring the income.

Loans From Your Business

- ✦ Copy of the past six monthly financial statements of all businesses owned or controlled by the offender that loaned money to the offender, including a detailed schedule of the "Loans To Shareholder/Owner" or "Due From Shareholder/Owner" general ledger accounts.

Mortgage Loans

- ✦ Copy of all mortgage checks received during the prior month, 1099 forms submitted with the prior year tax return, and copy of the sales agreement and escrow statement for all mortgage loans owed to the offender.

Other Loans

- ✦ Copy of loan documentation and copy of all loan checks received during the prior month.

Other (specify)

- ✦ Documentation verifying the source of all other monthly cash inflows (not yet disclosed or reported in these financial statements) and copy of all related monthly checks received.

REQUEST FOR MONTHLY CASH FLOW STATEMENT FINANCIAL RECORDS (cont.)

NECESSARY MONTHLY CASH OUTFLOWS

Rent or Mortgage (including taxes)

- Copy of apartment rental lease agreement or home mortgage, most recent mortgage statement, and verification of payment.

Groceries (# of people)

- Purchase receipts for the past month.

Utilities

- Copy of most current utility bills (e.g., electric, heating oil/gas, water/sewer, telephone, and basic cable).

Public Transportation

- Receipts of amount paid.

Car Payments

- Receipts for car lease or purchase payments.

Commuting Expenses

- Receipt for gasoline/motor oil, tolls, etc.

Insurance

- Copy of most current insurance bills for all types of insurance (auto, health, homeowners).

Clothing

- Purchase receipts with corresponding canceled checks.

Loan Payments

- Copy of loan statements for all loans. Also, provide a copy of any

Credit Card Payments

- Copy of most current billing statement for all charge accounts (e.g., credit

Medical

- Documentation of medical expenses (e.g., billing statements, payment

Alimony/Child Support

- Copy of divorce decree and statements documenting child support/alimony obligations with payment history.

Criminal Monetary Penalty

- Receipt of monthly payment

Court-Ordered Costs (electronic monitoring, drug/mental health treatment)

- Verification of payments, along with statement from the service provider

Other (specify)

- Specific receipts, billing statements.

ADDITIONAL INSTRUCTIONS:

A personal interview has been scheduled for you with:

_____ on _____

U.S. Probation Officer *Date*

at _____

Time

Office Location _____

Telephone _____

Last Name	First Name	Middle Name	Social Security Number

Instructions for Completing Monthly Cash Flow Statement

Having been convicted in the United States District Court, you are required to prepare and file with the probation officer a statement fully describing your financial resources, including a complete listing of all monthly cash inflows and outflows.

If you are placed on probation or supervised release (or other types of supervision), you may be periodically required to provide updated information fully describing your financial resources and those of your spouse, significant others, or dependents, as described above, to keep a probation officer informed concerning compliance with any condition of supervision, including the payment of any criminal monetary penalties imposed by the court (see 18 U.S.C. § 3603).

Your Cash Flow Statement should include assets or debts that are yours alone (I-Individual), assets or debts that are jointly (J-Joint) held by you and a spouse or significant other, assets or debts that are held by a spouse or significant other (S-Spouse or Significant Other) that you enjoy the benefits of or make occasional contributions toward, and assets or debts that are held by a dependent (D-Dependent) living in your home that you enjoy the benefits of or make occasional contributions toward.

Please complete the Monthly Cash Flow Statement in its entirety. You must answer "None" to any item that is not applicable to your financial condition. Attach additional pages if you need more space for any item. All entries must be accompanied by supporting documentation (see Request for Cash Flow Statement Financial Records (Prob. 48C)). Initial and date each page (including any attached pages) and sign and date the last page of the Cash Flow Statement.

Last Name -

MONTHLY CASH FLOW STATEMENT

Monthly Cash Inflows

Defendant	Gross	Net
Your Salary/Wages (List both monthly gross earnings and take-home pay after payroll deductions.)		
Your Cash Advances (List all payroll advances or other advances from work.)		
Your Cash Bonuses (List all payments from work in addition to your salary that are not an advance.)		
Commissions (List all non-employee earnings as an independent contractor.)		
Business Income (List both monthly gross income and net income after deducting expenses.)		
Interest (List all interest earned each month.)		
Dividends (List all dividends earned each month.)		
Rental Income (List all monthly income received from real estate properties owned.)		
Trust Income (List all trust income earned each month.)		
Alimony/Child Support (List all alimony or child support payments received each month.)		
Social Security (List all payments received from Social Security.)		
Other Government Benefits (List all amounts received from the government not yet reported (e.g., Food stamps and unemployment compensation)		
Pensions/Annuities (List all funds received from pensions and annuities each month.)		
Allowances-Housing/Auto/Travel (List all funds received from housing allowances, auto allowances, travel allowances, and any other kind of allowance.)		
Gratuities/Tips (List all gratuities and tips received each month from any and all sources.)		
Spouse/Significant Other Salary/Wages (List all gross and net monthly salary and wages received by your spouse or significant other.)		
Other Joint Spousal Income (List any monthly income jointly earned with your spouse or significant other [e.g., any income from spouse or income from a business owned or operated by the spouse that you have a joint ownership interest in or control]).		
Income of Other In-House (List all monthly income of others living in the household or the monthly amount actually paid for household bills by these persons.)		
Gifts from Family (List all amounts received as gifts from family members each month.)		
Gifts from Others (List all gifts received from any sources not yet reported.)		
Loans from Your Business (List all loan amounts received each month from all businesses owned or controlled by you.)		
Mortgage Loans (List all amounts received each month from mortgage loans owed to you.)		
Other Loans (List all other loan amounts received each month not yet reported.)		
Other (specify) (List all other amounts received each month not yet reported.)		
TOTALS		

Last Name -

Necessary Monthly Cash Outflows

	Amount
Rent or Mortgage (List monthly rental payment or mortgage payment.)	
Groceries (List the total monthly amount paid for groceries and number of people in your household.) #	
Utilities (List the monthly amount paid for electric, heating oil/gas, water/sewer, telephone, and basic cable.)	
Electric	
Heating Oil/Gas	
Water/Sewer	
Telephone	
Basic Cable (no premium channels)	
Public Transportation (List monthly amount paid for public transportation.)	
Car Payments (List all payments made to purchase or lease vehicles.)	
Commuting Expenses (List monthly amount paid for gasoline, tolls etc.)	
Auto Insurance (List the monthly amount paid for auto, health, homeowner/rental, and life insurance.)	
Health Insurance (List the monthly amount paid for homeowner/rental.)	
Homeowner/Rental Insurance (List the monthly amount paid for homeowner/rental insurance.)	
Clothing (List the monthly amount actually paid for clothing.)	
Loan Payments (List all monthly amounts paid toward verified loans, other than loans to family members, which are non-allowable expenses.)	
Credit Card Payments (List all minimum monthly credit card or charge card payments.)	
Medical (List all expenses not covered by insurance.)	
Alimony/Child Support (List all alimony or child support payments made each month.)	
Criminal Monetary Penalty (List all monthly payments for court-ordered criminal monetary penalties.)	
Court-ordered Costs (List the total monthly payments made for location monitoring and drug and mental health treatment.)	
Other (specify) (List all other necessary monthly amounts paid each month not yet reported.)	
Other Factors That May Affect Monthly Cash Flow (Describe)	
TOTAL	

NET MONTHLY CASH FLOW: $ **(CASH INFLOWS LESS NECESSARY CASH OUTFLOWS)**

MONTHLY CRIMINAL MONETARY PENALTY PAYMENT: $

PROSPECT OF INCREASE IN CASH INFLOWS (Give a general statement of the prospective increase of the value of any cash inflows reported.)

Signature _____ Date _____

PROB 48D
(Rev. 07/13)

DECLARATION OF DEFENDANT OR OFFENDER
NET WORTH & CASH FLOW STATEMENTS

I, _____, residing at _____, in the city (or county) of _____, in the state of _____, have completed the attached ☐ Net Worth Statement (Prob. Form 48) or ☐ Net Worth Short Form Statement (Prob. Form 48EZ) and/or ☐ Cash Flow Statement (Prob. Form 48B) that fully describe my financial resources, including a complete listing of all assets owned or controlled by me as of this date and any transfers or sales of assets since my arrest. The Cash Flow Statement (Prob. Form 48B) also includes my financial needs and earning ability and the financial needs and earning ability of my spouse (or significant other) and my dependent(s) living at home.

Net Worth Statement (Total pages, including additional pages _____)
Net Worth Short Form Statement (Total pages, including additional pages _____)
Cash Flow Statement (Total pages, including additional pages _____)

I declare under penalty of perjury that the foregoing is true and correct.

False statements may result in revocation of supervision, in addition to possible prosecution under the provisions of 18 U.S.C. § 1001, which carries a term of imprisonment of up to 5 years and a fine of up to $250,000, or both.

_____
(Defendant Signature)

Executed on
_____ day of _____, _____.

PROB 48E
(Rev. 07/13)

CUSTOMER CONSENT AND AUTHORIZATION FOR ACCESS TO FINANCIAL RECORDS FOR PRESENTENCE REPORT

I, _____ , having read the explanation
(Name of Customer)
of my rights, which is attached to this form, and having been convicted in the U.S. District Court, in accordance with Rule 32(d)(2)(A)(ii) (and 18 U.S.C. § 3664(d)(3) when restitution may be imposed), hereby authorize the

_____
(Name and Address of Financial Institution or Credit Agency)

to disclose the following financial records:

to _____ , an officer of the
(Name of Probation Officer Allowed Access)
U.S. District Court for the District of New Jersey ,
(Name of District Court)
to obtain information on assets I own or control, fully describing my financial resources to the United States probation officer for the purpose of preparing a presentence investigation report.

I understand that this authorization may be revoked by me in writing at any time before my records, as described above, are disclosed and that this authorization is valid for no more than three (3) months from the date of my signature. I understand further that my authorization cannot be required as a condition of my doing business with the above-named financial institution.

_____ _____
(Date) *(Signature of Customer)*

_____ _____
(Social Security Number of Customer) *(Date of Birth of Customer)*

_____
(Address of Customer)

_____
(City/State/Zip Code)

Section 1104(a) of the Right to Financial Privacy Act, 12 U.S.C. § 3404(a).

STATEMENT OF CUSTOMER RIGHTS UNDER THE RIGHT TO FINANCIAL PRIVACY ACT OF 1978

Federal law protects the privacy of your financial records. Before banks, savings and loan associations, credit unions, credit card issuers, or other financial institutions may give financial information about you to a federal agency, certain procedures must be followed.

Consent to Financial Records

You may be asked to consent to make your financial records available to the government. You may withhold your consent, and your consent is not required as a condition of doing business with any financial institution. If you give your consent, it can be revoked in writing at any time before your records are disclosed and, in any event, is effective for a period of not more than three months. Your financial institution must keep a record of the instances in which it discloses your financial information to the government, and this record will be available to you upon request, unless a court order restricting your right to such record has been obtained by the government.

Without Your Consent

Without your consent, a Federal agency that wants to see your financial records may do so ordinarily only by means of a lawful subpoena, summons, formal written request, or search warrant for that purpose.

Generally, the Federal agency must give you advance notice of its efforts to obtain your records by one of the above means, explaining why the information is being sought and telling you how to object in court to the release of your records.

Exceptions

If the government obtains a search warrant for your records, or if the government convinces the court that there are legitimate reasons to delay giving you notice, the Federal agency will be able to obtain your records without providing you notice beforehand.

In situations where you do not receive advance notice that the government is seeking your financial records, you will be notified once the reason for the delay of notice no longer exists.

Transfer of Information

Generally, a Federal agency which obtains your financial records is prohibited from transferring them to another Federal agency unless it certifies in writing that the transfer is proper and sends a notice to you that your records have been sent to another agency.

Penalties

If the Federal agency or financial institution violates the Right to Financial Privacy Act, you may sue for damages or to seek compliance with the law. If you win, you may be repaid your attorney's fees and costs.

Authorization for Release of Health Information to the U.S. Probation Office, District of New Jersey Pursuant to the Privacy Rule of HIPAA

Name:

Date of birth:

Home address:

1. Name and address of health care provider or entity to release this information:

2. Name and address of person(s) to whom this information will be sent:

   Name of U.S. Probation Officer:

   Mailing address: U.S. Probation Office, 50 Walnut St., Room 1001, Newark, N.J. 07102

   U.S. Probation Officer email address:

3. Reason for release of information:
   Court-ordered presentence investigation

4. Date or event on which this authorization will expire:

I request that the health information regarding my care and treatment be released as set forth on this form.
In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

5. This authorization may include, but is not limited to, disclosure of information relating to alcohol and drug abuse, mental health treatment, and confidential HIV-related information only if I place my initials on the appropriate line in item 11(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 11(a), I specifically authorize release of such information to the U.S. Probation Office.
6. If I am authorizing the release of alcohol or drug treatment, mental health treatment, or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
7. I have the right to revoke this authorization at any time by writing to the health care provider listed above.
8. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
9. Information disclosed under this authorization may be redisclosed by the recipient, and this redisclosure may no longer be protected by state or federal law.
10. This authorization does not authorize you to discuss my health information or medical care with anyone other than the U.S. Probation Office.

11. (a) Specific Information to be released:

    Please check one:

    ☐ Entire medical record

    ☐ Medical record from _____ (date) to _____ (date)

    ☐ Other (specify) _____

    By initialing below, I give additional consent for the following restricted medical information to be released.

    ☐ Drug/alcohol/addiction treatment records _____ (initials)

    ☐ Mental health treatment records _____ (initials)

    ☐ HIV-related information _____ (initials)

    (b) By signing below, I authorize for all information checked/initialed in item 11(a) to be released by the health care provider listed at item 1 to the U.S. Probation Office. I further give consent for the health care provider to discuss my records with the U.S. Probation Office.

    X _____ (signature) _____ (date)

    (c) Witness _____ (signature) _____ (date)

✎PROB 11G
(Rev. 5/03)

AUTHORIZATION TO RELEASE INFORMATION
(PRIVATE PERSON OR ORGANIZATION)
TO PROBATION OFFICER

TO WHOM IT MAY CONCERN:

I, _____, the undersigned, hereby authorize the United States Probation Office for the _____ District of New Jersey, or its authorized representative(s) or employee(s), bearing this release or copy thereof, to obtain any information in your files pertaining to my:

- ☐ Employment
- ☐ Education Records (including, but not limited to academic achievement, attendance, athletic, personal history, and disciplinary records)
- ☐ Medical Records
- ☐ Psychological and Psychiatric Records

I hereby direct you to release such information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for the United States Probation Office's official use.

I hereby release you, as custodian of such records, any school, college, or university, or other educational institution; hospital or other repository of medical records; social service agency; any employer or retail business establishment, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

Regarding protected health information, I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Regarding protected health information, I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____ .
(Name and Address of Program)

Regarding protected health information, I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

_____	_____	_____
(Authorizing Signature - Full Name)	(Full Name - Printed or Typed)	(Date)
WITNESS —	_____	_____
	(Probation Officer)	(Date)

✎PROB 11H
(Rev. 5/03)

AUTHORIZATION
TO RELEASE GOVERNMENT (STATE OR FEDERAL) INFORMATION
TO PROBATION OFFICER

I, _____, the undersigned, hereby waive my rights under the Privacy Act, 5 U.S.C. 552a (Supp. IV, 1974), and authorize the disclosure to the United States Probation Office of the _____ District of New Jersey, or its authorized representative(s) or employee(s), any and all information pertaining to me, contained in the files or systems of records maintained by any government agency subject to the Privacy Act, which such agency sees fit to convey, either orally or in writing, to the aforementioned Probation Office.

I hereby waive any rights I may have under the Privacy Act to prior notice of such disclosure, or of any rights I may have to an accounting of such disclosure to the aforementioned Probation Office.

I understand that this authorization will be used by the aforementioned Probation Office to request disclosure of information pertaining to me from any or all federal or state agencies.

This information is to be obtained for the purpose of conducting a presentence investigation and making a report or for supervision.

Regarding protected health information, I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Regarding protected health information, I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

Regarding protected health information, I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires this information will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

Authorizing Signature (full name)	Full Name (printed or typed)	Date
	Parent/Guardian Signature, if Required	
	Attorney Signature, if Available	
WITNESS —	Probation Officer	Date

✎ PROB 11E
(Rev. 5/05)

UNITED STATES PROBATION SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT PROGRAMS

I, _____, the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)
information in its records, possession, or knowledge of whatever nature may now exist or come to exist to the United States Probation Office of the _____ District of New Jersey.
(Name of Court) (State)

The confidential information to be released will include: date of entrance to program; attendance records; urine testing results; type, frequency and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (psychological, vocational, etc.); psychotherapy notes; date of and reason for withdrawal from program; and prognosis.

The information which I now authorize for release is to be used in connection with the preparation of a court-ordered report.

I understand that the probation office may use the information hereby obtained only in connection with its official duties, including total or partial disclosure of such, to the District Court.

I understand that this authorization is valid until I have been sentenced and my sentence is final, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before the completion of the presentence investigation will be reported to the court.

_____ _____
(Signature of Parent or Guardian if Client is a Minor) (Signature of Client)

_____ _____
(Date Signed) (Date Signed)

_____ _____
(Name & Title of Witness) (Date Signed)

New Jersey Department of Education
Phone: 609-777-1050
Email: adultedinfo@doe.state.nj.us
Website: www.state.nj.us/education/students/adulted

ACCESS CODE REQUEST FORM FOR OFFICIAL HIGH SCHOOL EQUIVALENCY TRANSCRIPT AND STATE-ISSUED HIGH SCHOOL DIPLOMA VERIFICATION

Instructions: The New Jersey Department of Education requires the following information in order to issue an access code that provides access to your Official Transcript of High School Equivalency Tests Results and/or your State-issued high school diploma verification record. Please contact the New Jersey Department of Education at (609) 777-1050 if further information is required.

PLEASE PRINT CLEARLY: GED Recipient's Current Information		
First Name	Middle Initial	Last Name
Name at time of test if different from above		
Date of Birth	Social Security Number	
Phone number	Alternate phone number(s)	State of Residence
Email Address:		

I authorize the New Jersey State Department of Education to release my private **High School Equivalency Access Code** to me. It is my understanding that the ***E-Transcript/Diploma Verification*** serves as the ***Official Transcript of High School Equivalency Test Results/Official Diploma Verification.*** This Official document contains a unique ***Verification Code.*** It is my responsibility to provide this Official document to third parties as requested (including employers, colleges and universities, military, etc.) to verify the authenticity of the document presented.

Signature of Recipient Who Took The Test (No electronic or typed signature accepted. Original written signature required.)	Date of Request
Sign **X**_____	

Mail, fax, or email signed form to:

NJ DOE Office of Adult Education
PO Box 500
Trenton, NJ 08625-0500

Fax Number: 609- 292-3768
Email: adultedinfo@doe.state.nj.us

State of New Jersey
STATE DISBURSEMENT UNIT
PO BOX 5485
TRENTON NJ 08638-0485
Telephone: (877)855-4871 Fax: (609)570-4289
Office of Child Support Services

Third Party Authorization to Release Information to an Authorized Agency/Office

This form gives the NJ Child Support Program (NJCSP) the legal authorization to release information about your child support case to a designated third party. Internal Revenue Service regulations restrict the release of IRS data. If the information being requested has been filed with a court, it may be able to be obtained from the appropriate Clerk of Court.

Please complete and return both pages of this form to the above address by mail or fax. This completed document must be received by the NJ Child Support Program before we will be able to speak with your authorized representative about your case. This document will be maintained by your local Child Support Office in your official child support case record. A copy of this authorization may be accepted as an original.

I, _____ _____
Type or print your name as provided to this agency Case #

residing at : _____
Address City State Zip

authorize the NJ Child Support Program to disclose to:

_____
Name of Authorized Agency / Organization / Office / Law Firm

_____ _____ _____
Authorized Representative Title/Affiliation/Attorney ID# Contact Information (phone/e-mail)

Reason and Purpose for Request:

_____

_____

_____

_____

I understand that my records are protected under federal and state laws and regulations governing the confidentiality of Child Support records. I authorize the NJ Child Support Program to release information regarding the above child support case to the above designated third party. NJCSP can release information only about the individual whose signature appears

below. Information regarding the other party to the child support case cannot be released. Said third party shall be liable for any willful misuse of any information released under this authorization.

This authorization is only relative to the above listed reason/purpose. Information will be released on a one-time only basis or until resolution of the issue. A new authorization form must be completed for every request to release information. Said authorization can be revoked by me at any time for any reason upon written notice. Any such notification of revocation shall not invalidate previously made disclosures of information pursuant to a valid authorization. I further understand that this authorization automatically expires if the case is closed.

I hereby release the NJ Child Support Program, including all of its component agencies and offices, from liability for the release of any information under this authorization.

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ Date : _____

Signature of Person Authorizing Release of Information(CP/NCP)

✎ PROB 11A
(9/77)

UNITED STATES DISTRICT COURT
FEDERAL PROBATION SYSTEM

AUTHORIZATION TO RELEASE CONFIDENTIAL MILITARY INFORMATION

NAME (Last, First, Middle)	DATE OF BIRTH	DATE SIGNED

The above named individual is a defendant before the U.S. District Court for the _____

District of New Jersey

The requested documents are necessary to complete an official report ordered by this court.

I authorize release to the United States probation office all confidential records and information concerning me, including any information contained in a system of records of a government agency or other agencies and facilities subject to the Privacy Act or similar restrictions.

This authorization shall remain in effect until it is revoked in writing.

_____ _____
(Signature of Defendant) (Date)

WITNESS: _____ _____
(Signature of Probation Officer) (Date)

AUTHORIZATION FOR RELEASE OF MILITARY MEDICAL PATIENT RECORDS (Drug Rehabilitation)

The National Personnel Records Center, General Services Administration, is hereby authorized to release copies of my military medical treatment records as described below.

NAME OF PERSON AUTHORIZED TO RECEIVE RECORDS

NAME AND ADDRESS OF FACILITY TO RECEIVE RECORDS

PLACE WHERE TREATMENT OCCURRED	APPROXIMATE PERIOD OF TREATMENT

SPECIFIC TYPE OF TREATMENT INVOLVED

PURPOSE FOR WHICH RECORDS ARE NEEDED

THIS AUTHORIZATION EXPIRES WITHOUT EXPRESS REVOCATION 12 MONTHS FROM THE FOLLOWING DATE.

DATE	SIGNATURE OF INDIVIDUAL WHOSE RECORDS ARE REQUESTED

AUTHORIZATION TO RELEASE STATE OF NEW JERSEY JUDICIARY PRESENTENCE INVESTIGATION REPORT TO THE UNITED STATES PROBATION OFFICE, DISTRICT OF NEW JERSEY

I, _____, the undersigned was the subject of a criminal prosecution by the State of New Jersey. During that prosecution, the State of New Jersey Judiciary prepared a Presentence Investigation report ("PSI") pursuant to N.J.S.A. 2C:44-6. I, and/or my attorney, was provided with a copy of the PSI, along with all attachments to it, in connection with my sentencing in that New Jersey case.

I authorize the release of the PSI, and all of its attachments, to the United States Probation Office, District of New Jersey. I understand that this authorization will be used by the United States Probation Office, District of New Jersey, only for the purposes of conducting a presentence investigation and making a report, or for supervision.

I understand and agree that my PSI may include records and information that may be protected by Federal Law: specifically, the Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 CFR Part 2); and/or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), (45 CFR Parts 160 and 164); and by New Jersey law under the AIDS Assistance Act, specifically N.J.S.A. 26:5C-7 and -8.

Regarding any protected health information, I understand that this authorization is valid until my release from federal supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the United States Probation Office, District of New Jersey, and may no longer be protected by federal or state law.

Regarding protected health information, I understand that I have the right to revoke this authorization, in writing at any time by sending written notification to: **State of New Jersey Judiciary**_____.

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before the completion of the presentence investigation may be reported to the federal court.

I hereby release, indemnify and discharge the State of New Jersey, its employees, agents or contractors from any and all actions, I, my representatives or assigns now have or may have hereinafter for injury or damage resulting from the disclosure of the records and information described above.

I have carefully read this release and fully understand its contents. I am legally competent to sign this authorization. I hereby acknowledge that I have signed this release of my own free will, and that I have received a copy of the release.

_____	_____	_____
Date	Signature	Printed Name
_____	_____	_____
Date	Witness Signature	Witness Printed Name

NEW JERSEY JUVENILE JUSTICE COMMISSION

09ED:01.09A

(Revised: 12/6/18)

CONFIDENTIAL

RECORDS REQUEST FORM

To provide the records you are requesting, we ask that you complete and return this form. Copies will be provided at 5 cents per page for letter size and 7 cents per page for legal size. There may be additional fees for delivery and postage depending upon delivery type. There is no charge if documents are sent by email.

Payment must be received prior to disclosing the information. You will be notified within seven (7) business days of receipt of the form whether access to the records has been granted or denied. If access is granted, you will also receive an invoice for the total amount due. If access is denied, you may file an appeal with the JJC Executive Director.

Juvenile's name: _____ Birth date (if known): _____

Juvenile Number: _____

Individual or agency requesting records: _____ Date: _____

Address: _____

_____

_____

Telephone number: _____ Fax number: _____

Email: _____

Record Request Information: To expedite the request, be as specific as possible in describing the records being requested. Also, please include the type of access requested (copying, inspection, or examination), and if data, the medium requested.

_____

_____

_____

_____

Signature of Requestor: _____ Date: _____

***PLEASE NOTE: If the juvenile is under 18 years old, a parent or guardian must sign this form.**

Juvenile Justice Commission Use Only

☐ Access has been approved

☐ Access has been denied Reason for denial: _____

Name of Custodian: _____ Title: _____

Signature of Custodian: _____ Date: _____

Amount billed: _____ Date billed: _____

Date payment received: _____ Received by: _____

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

Resident Name: _____

Date of Birth: _____ **Juvenile Number**_____

Person/Organization Requesting Information:
_____

_____

_____

Person/Organization Providing Information:
Juvenile Justice Commission
P.O. Box 107
Trenton, New Jersey 08625-0107

Description of Protected Information Requested (including dates): Any and all documents that refer, relate, or in any way pertain to information you may have regarding _____, including (medical/psychological, education, classification, correspondence or any other documents related to this office's examination, consultation, treatment or other services provided to _____.

Description of Reason for Disclosure: This disclosure is to assist in legal representation. I understand that if my records contain 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), that my signing this document authorizes the release of that information. I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege.

You are hereby requested and authorized to furnish to _____ all documents and information (including protected information as defined above) that you may have regarding _____.
I understand that the information to be released may be re-disclosed by the recipient and no longer subject to the protection of the Federal Privacy Regulations.
I understand that this authorization is voluntary and that I may revoke it at any time by notifying the requesting person/organization in writing that I am revoking the authorization. Such actions will not affect actions taken by the requesting person/organization prior to the date they receive your written request to revoke the authorization.
I understand that I am entitled to receive a copy of this authorization.

_____ _____
Signature of Resident* or Resident's Authorized Representative Date

_____
If signature is authorized representative, indicate relationship

***PLEASE NOTE: If the juvenile is under 18 years old, the parent or guardian must sign this form.**

BP-A621.060
FEB 05

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Inmate Name	Register Number	Date
	Date of Birth	Social Security Number

I hereby authorize and request the Federal Bureau of Prisons to:

☑ release information to, or ☐ obtain information from

PLEASE CONTACT IF PAYMENT IS REQUIRED PRIOR TO FILLING REQUEST

Name/Facility:_____

Address:_____

City, State, Zip:_____

_____

I understand the information is to be used for (specific reason for release of information):

☐ Continuation of care, or ☑ Other _____

_____

Information to be Released/Obtained: Copy of and/or information from my medical file pertaining to my evaluation and treatment received from _____ to _____.

This is to include:
☑ Complete Record ☐ Discharge Summary ☐ History & Physical
☐ Operative Reports ☐ Consultations ☐ Progress Notes ☐ X-ray Reports
☐ Laboratory Reports ☐ Pathology Reports ☐ Actual Films***#** ☐ Actual Slides*****
☐ Other:_____

***will be returned**
#duplicates accepted

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that I may revoke this consent at any time by sending a written notice to the Supervisor of Medical Records. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. This authorization will automatically expire three months from the date of the signature.

Signature of Patient	Date (Month, Day, Year)	Staff Witness
FAX SIGNATURE VALID ORIGINAL		

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW.
Must sign below, to Release Protected Information.

I specifically authorize the release of data and information relating to:
☑ 1. Substance Abuse ☑ 2. Mental Health ☑ 3. HIV

_____
Signature Date

Deliver Records To: (Institution Address & Fax number)

Newark Beth Israel Medical Center | **RWJBarnabas HEALTH**

MR # _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ D.O.B.: _____

ADDRESS: _____ _____ _____ _____
CITY STATE ZIP

TELEPHONE: _____

I hereby authorize the ***Newark Beth Israel Medical Center*** to disclose my health information to:
(Specify to whom the information will be mailed. Document M.D. if no record is to be mailed to a physician)

_____
REQUESTOR'S NAME

_____
REQUESTOR'S ADDRESS

_____ _____ _____
CITY **STATE** **ZIP CODE**

The information to be disclosed to and used by the above is for the following purpose: ☐ Continuity of Care/Medical ☐ DYFS
☐ Disability ☐ Social Security ☐ Legal ☐ Insurance ☐ Personal

This authorization is limited to the following dates of treatment:

FROM _____ TO _____

Information to be disclosed:

☐ **EMERGENCY ROOM RECORD**	☐ **CONSULTATIONS**	☐ **COMPLETE RECORD**
☐ **HISTORY & PHYSICAL EXAM**	☐ **PROGRESS NOTES**	☐ **ABSTRACT**
☐ **OPERATIVE REPTS & PATHOLOGY**	☐ **LAB, X-RAYS & TESTS**	☐ **AUTOPSY REPORT**
☐ **DISCHARGE SUMMARY**	☐ **NURSES' NOTES**	☐ **OTHER** _____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that this revocation will not apply to the extent that Newark Beth Israel Medical Center has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can ***contact the Medical Records Department at (973) 926-7409.***

PATIENT SIGNATURE: _____ DATE: _____

If legal representative, sign below and state relationship and authority to do so and attach the document of authority.

LEGAL REPRESENTATIVE: _____ DATE: _____

RELATIONSHIP: _____

WITNESS: _____ DATE: _____

UNIVERSITY HOSPITAL
Newark, New Jersey

Health Information Management
150 Bergen Street, B417
Newark, NJ 07101-6750
(973) 972-5604

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Please PRINT (except signature) and all sections must be completed.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Telephone Number: _____

1. I authorize University Hospital to disclose my medical records to:

   _____

   _____

   (Name and address of person or institution to whom the disclosure is made)

2. This authorization is limited to the following dates of treatment:

   FROM: _____ TO: _____

   Information to be disclosed:

   _____

   _____

   (Provide specific type of records or request "complete medical record," note billing records must be requested separately)

3. Purpose of disclosure: ❑ Medical Care ❑ Legal ❑ Insurance ❑ Other: _____

4. **I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as applicable. If you wish not to release any of the above mentioned inform please indicate below. Otherwise this information will be released.**

   Do not release the following: _____

5. This authorization may be revoked at any time by sending written notice to the Director of Health Information Management at the above address, except to the extent that University Hospital has already taken action in reliance on it. If not previously revoked, this authorization will automatically expire one year from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: _____

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

Signature of patient or legal guardian: _____ Date: _____

Relationship, if not the patient: _____

Note: Please mail completed form to address noted above.

capitalhealth

☐ Capital Health
Regional Medical Center
750 Brunswick Avenue
Trenton, New Jersey 08638
609 394 6000

☐ Capital Health
Medical Center - Hopewell
One Capital Way
Pennington, New Jersey 08534
609 303 4000

☐ Capital Health - Hamilton
1445 Whitehorse-Mercerville Road
Hamilton, New Jersey 08619
609 588 5050

capitalhealth.org

Authorization for Patient Access/Release of Health Information

Patient Name:		Medical Record #:
Date of Birth:	Social Security #: XXX-XX- _____	Phone #:
Home Address:	City:	State: Zip:

1. Type of Request: I hereby request the following:
   - ☐ Access to review my original medical record
   - ☐ Release/Disclosure of my health information, as requested below
   - ☐ Request my medical records from another facility — *Name of Facility:* _____

2. Description of Information To Be Released: *(Check ALL that apply)*
   - ☐ Abstract* (defined below)
   - ☐ Entire Medical Record
   - ☐ History and Physical
   - ☐ Operative Reports
   - ☐ Immunization Record
   - ☐ ER Record
   - ☐ Progress Notes
   - ☐ X-ray Reports
   - ☐ Outpatient Records
   - ☐ Consultation Reports
   - ☐ EKG/EEG
   - ☐ Discharge Summary
   - ☐ Treatment Record
   - ☐ Labs
   - ☐ Other (*specify):* _____

   Date of Service _____

   *(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, test results)*

I understand that the specific information to be released may include reference to alcohol abuse, drug abuse, AIDS/HIV infection, sexually transmitted diseases, tuberculosis, genetic information, and/or psychiatric conditions and the treatment of any of these disorders. If this information is documented in my medical record, I agree to the release of it.

3. Disclose/Send Information To:
   - ☐ Myself *(the patient or authorized representative)*
   - ☐ To Organization/Individual below:

Organization:	Individual Name:		Phone #:
Street Address: City:	State:	Zip Code:	☐ Please Mail ☐ Please Fax: _____ ☐ Please prepare for pick-up

4. Purpose of Release: I authorize Capital Health to release my health information for the following specific purpose:

_____

5. Term/Expiration:
I understand that by law, I do not have to release this information and I choose to do so voluntarily. I may cancel this authorization by providing a written revocation to Capital Health, Health Information Management Department at the Regional or Hopewell address listed above. This authorization will automatically expire twelve (12) months from the date listed below. *I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it is no longer protected by Federal Privacy Regulations and that the information could be re-disclosed without my permission.*

6. Fees:
Capital Health charges a reasonable fee for retrieval of medical records and preparation of photocopies for purposes other than patient care.

_____ _____
Signature of Patient or Patient's Representative — Date

_____ _____
Relationship to Patient — Witness Signature

Cooper University Hospital

AUTHORIZATION FOR USE OR DISCLOSURE OF PHI

I, _____, hereby authorize Cooper University Hospital to use the health information about me
(*Print Name*)
that is specified below, and to disclose such health information to

_____
(Identification of recipient, address, telephone number)
for the following purposes:

_____.

If the above purpose(s) includes the use or disclosure of your health information for Cooper University Hospital's marketing purposes, or another entity's marketing, Cooper University Hospital **will/will not** be paid, either directly or indirectly, for using or disclosing your health information for such marketing purpose(s).

DESCRIPTION OF HEALTH INFORMATION SUBJECT TO THIS AUTHORIZATION

Date(s) of Service _____

[ ]	Admission Record	[ ]	Operative Reports	[ ]	AIDS or HIV-related information
[ ]	Discharge Summary	[ ]	X-Rays	[ ]	Other (specify)_____
[ ]	Emergency Department Record	[ ]	Laboratory Results		
[ ]	History and Physical Consultation(s)	[ ]	Psychiatric Records		
[ ]	Pathology Report(s)	[ ]	Drug abuse and/or alcoholism treatment records		
[ ]	Consultations				

This authorization will expire on _____ or when the following event happens:
_____.

This authorization will automatically expire one year from the date it is given. An authorization for disclosure of psychiatric records will automatically expire 60 days from the date it is given.

I understand that I may revoke this authorization at any time, even if it has not expired, by giving a written notice to the Director of Health Information Management. I understand that my revocation will become effective on the day it is received by Cooper University Hospital. I also understand that Cooper University Hospital may, under certain circumstances, have a continued right to use or disclose my health information if Cooper University Hospital has already used or disclosed the information on the basis of this authorization.

I understand that if I am giving this authorization as a condition of receiving insurance coverage, Cooper University Hospital may have access to health information about me if there is a question about a claim I made under the insurance policy. I understand that a full description of other rights that I may have in regard to a revocation of this authorization can be found in Cooper University Hospital's Notice of Privacy Practices.

Notice to the Individual Giving This Authorization

Your failure to give this authorization may result in the withholding of treatment or services from you, if the treatment is research-related or if the services were to be provided only for the purpose of creating health information about you.

This Authorization shall operate as a complete release of liability of Cooper University Hospital, its trustees, officers, agents and employees for the release of information as specified above.

Once Cooper University Hospital discloses information on the basis of this authorization, we have no control over the recipient's use of the information. The person to whom we disclose your information may disclose it to someone else, and Cooper University Hospital will no longer be able to protect the information.

_____ _____
Patient Signature *Date* *Authorized Representative* *Date*

_____ _____
Print Name *Print Name* *Relationship to Patient*

Address:_____ Patient's Date of Birth:_____

✎PROB 74
(9/99)

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

INFORMATION RELEASED BY:	INFORMATION RELEASED TO:
Name	Name
Organization	Organization
Address	Address
City, State, Zip Code	City, State, Zip Code

SUBJECT OF RECORD

Name	Date of Birth
Address	Identifying Number
City, State, Zip Code	

Specific Records Authorized for Release (Include dates of records, if applicable.)

Purpose or Need for Release of Information (Be specific.)

I understand that I may revoke this authorization in writing at any time, except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated and initialed below.

☐ Authorization expires as of _____ .

☐ Authorization expires _____ month(s) from signature date.

☐ Authorization expires _____ month(s) from signature date.

As evidenced by my signature below, I hereby authorize disclosure of records to the person(s) or agency(s) as specified above.

Signature of Subject of Record	Date
Signature of Other Legally Authorized Person (if applicable)	Date

Relationship to Subject of Record

Authorization for Use or Disclosure of Protected Health Information

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. **I,** _____, **authorize the disclosure of information from my medical record.**
(Name of Patient)
Birthdate: _____ **SSN (Last 4 digits): XXX-XX-**_____

II.

The information is to be disclosed by:	**And is to be provided/sent to:**
NAME OF FACILITY Jersey City Medical Center	*NAME OF PERSON/ORGANIZATION/FACILITY*
ADDRESS 355 Grand Street	*ADDRESS*
CITY, STATE, ZIP Jersey City, NJ 07302	*CITY, STATE, ZIP*

III. **Purpose or need for this disclosure is:**

☐ Continued Treatment ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other_____

IV. **Information to be disclosed from my medical record:** ***(Check appropriate box(es))***

☐ Only information related to (specify) _____
_____
☐ Only for dates of service from _____ to _____
☐ Other (specify) (ex: radiology, billing, etc.) _____
☐ Entire Record

V. **If you would like any of the following sensitive information disclosed, check the applicable box(es) below:**

☐ Alcohol/Drug Abuse Treatment/Referral ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Sexually Transmitted Diseases ☐ Genetic Testing
☐ HIV/AIDS Testing & Treatment ☐ Sexual & Reproductive Health

VI. I understand that by signing this authorization, my Treatment, Payment and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

VII. I understand that the information disclosed may be subject to redisclosure by the person or entity receiving it and would then no longer be protected by federal privacy regulations.

VIII. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any actions already taken based on this authorization cannot be reversed and my revocation will not affect those actions.

IX. This authorization expires on _____, 20_____, OR upon the following event:
_____.
If no date or event is specified, the authorization will automatically expire one (1) year from the signature date.

_____ _____
SIGNATURE OF PATIENT *DATE*

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE & RELATIONSHIP TO PATIENT *DATE*

_____ _____
SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark) *DATE*

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (continued)

DO NOT WRITE IN THIS AREA

PATIENT LABEL

PATIENT NAME: _____ (Last) (First)

DOB: _____

ACCOUNT #: _____

MRN #: _____

I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of treatment of me, enrollment in the health plan, or eligibility for benefits.

I understand that this Authorization will remain in effect until it expires as set forth above, or I provide a written notice of revocation to the attention of the Health Information Management Department (HIM) at the address listed above. The revocation will be effective upon HIM's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Hospital in reliance on this Authorization before it received my written notice of revocation.

If I have questions about the disclosure of my health information, I can contact the Health Information Management Department at 201-915-2151.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Hospital to use or disclose my health information in the manner described above.

_____ _____ _____

Signature of the Patient **Date** **Signature of Witness or Employee**

If the patient does not have legal capacity or is otherwise unable to sign this Authorization, please sign and complete the information below:

_____

Signature of authorized Legal Guardian, Health Care Agent or other authorized Personal Representative

(Please attach documents supporting relationship as Legal Guardian, Health Care Agent or other authorized Personal Representative)

_____ _____ _____

Relationship **Date** **Witness**

For Office Use Only:

ID checked: YES or NO ID type: _____

Date Released: _____ Time: _____

Signature: _____ Printed Name: _____

Medical Record Request Fees:

Medical records are provided at no cost when the records are requested to be sent to another healthcare provider for patient care. For all other requests, there is a charge to the patient/requestor.

To submit this form to HIM: (You must also include a copy of a form of identification when submitting.)

1. **Fax to 201-915-2559 or 201-915-2556.**
2. **Call 201-915-2151 to obtain an email address to submit via email.**
3. **Send paper request via mail.**

[provide a copy of signed Authorization to patient]

DO NOT WRITE IN THIS AREA

DO NOT WRITE IN THIS AREA