

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

Following conviction, whether by plea or guilty verdict, the Court will set a schedule for sentencing, including the preparation of the presentence investigation report and the parties' submissions to the Probation Office. The presentence report will aid the Court in determining an appropriate sentence.

To assist in the presentence investigation, please complete the attached Worksheet for Presentence Report and all financial forms. As indicated on the instructions, financial information must be accompanied by supporting documentation, as necessary. 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](mailto:njp_Presentence@njp.uscourts.gov)**

In the subject line of the email, please list the courthouse location where the case is assigned, followed by your name. For example, "Camden – John Smith."

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 (alien registration 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:

<b>Newark:</b>	Donald L. Martenz, Jr. – (973) 223-0236 and Natalie Shreve (973) 936-4852
<b>Trenton:</b>	Shavaughn M. Chapman - (201) 618-4256
<b>Camden:</b>	Matthew F. Hulick – (856) 305-7994

**UNITED STATES DISTRICT COURT  
DISTRICT OF NEW JERSEY  
UNITED STATES PROBATION OFFICE**

**WORKSHEET FOR PRESENTENCE REPORT**

<b>FACESHEET DATA</b>		
Name: _____		
Aliases or Nick Names: _____		
Docket #: _____ Judge: _____		
Arrest Date: _____		
Assistant U.S. Attorney: (Name, Address)		Defense Counsel: (Name, Address, Telephone)
_____		_____
_____		_____
_____		_____
Retained <input type="checkbox"/> Assigned <input type="checkbox"/>		
<b>DEFENDANT'S IDENTIFICATION</b>		
Place of Birth: _____ Date of Birth: _____ Age: _____		
Social Security #: _____		
Race: White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/>		
Hispanic Origin: Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/>		
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Country of Citizenship: _____		
Immigration Status: _____ Alien Registration #: _____		
<b>RESIDENTIAL INFORMATION</b>		
Current Address: _____		
(Number and Street)		Apt. #
_____		
(City)	(State)	(Zip)
Mailing Address: _____		
(Number and Street)		Apt. #
_____		
(City)	(State)	(Zip)
Email Address(es): _____		
Home Phone Number: _____ Cellular Phone Number: _____		

### RELEASE STATUS

In Custody: \_\_\_\_\_ Where: \_\_\_\_\_ Since What Date: \_\_\_\_\_

Bond: \_\_\_\_\_ Type: \_\_\_\_\_

Pretrial Supervision: Yes ☐ No ☐ Pretrial Services Officer's Name and #: \_\_\_\_\_

### ACCEPTANCE OF RESPONSIBILITY

Version of the offense. This statement may be handwritten or typed. You should include, but are not limited to, the following information about the crime of conviction:

Why did you become involved? What influenced your involvement in this offense? (i.e., peers, personal circumstances...)

What impact has your behavior had on others?

What did you receive from this offense?

What was your relationship with your co-conspirators/co-defendants, if any?

What could you have done differently to avoid finding yourself in this situation? What can you do differently in the future to avoid finding yourself in a similar situation?

**CRIMINAL HISTORY (Juvenile and Adult)**

☐ None.

Date of Arrest, Prosecution, Referral, or Detention	Charge/ Conviction	Court City/County/State Docket No.	Date Sentenced or Case Disposed	Sentence	Represented by or Waived Counsel (Y) or (N)

**PENDING CHARGES AND SUPERVISION STATUS**

☐ No pending charges.

Charge(s)	Court	Accusation/Indictment #	Next Appearance Date

☐ Not currently under supervision (diversion, probation, supervised release, or parole supervision).

☐ Currently under criminal justice sentence. What type of supervision?

- ☐ Probation      ☐ State ☐ Federal  
☐ Supervised Release  
☐ Parole  
☐ Conditional Discharge  
☐ Pretrial Intervention  
☐ In custody  
☐ Other

Supervising Officer's Name and Telephone Number:

\_\_\_\_\_

\_\_\_\_\_

### OFFENDER CHARACTERISTICS

Life/Residential History: Please list every town where you have lived, how long, and with whom. Please be specific, include parents, step-parents, or any other important information.

Are you affiliated with any gangs? \_\_\_\_\_

### PARENTS AND SIBLINGS

(List your biological parents. If raised by persons other than your natural parents, add the surrogate parents' names immediately below the space allocated to Father and Mother. After the parents, list all siblings, both living and deceased.)

Name	Relationship and Age		Present Address and Telephone Number	Occupation
	Father			
Current Name: Maiden Name:	Mother			

Indicate whether any family members have any health problems, criminal history, substance abuse issues, or mental or mental health issues.

Include if any of the following have impacted you: divorce of parents; physical abuse or sexual abuse; serious injury or illness; domestic violence or gambling:

Family Verification Contact Person: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### MARITAL STATUS

☐ Presently single with no marital history.

Spouse/ Domestic Partner (Current)	Date and Place of Marriage	Status	Date of Separation	Date of Divorce	Court Where Divorce was Granted	Number of Children

Employment status of current spouse:

Does partner have criminal history? History of substance abuse/mental illness?

### CHILDREN

☐ No children.

Child's Name	Name of Other Parent of this Child	Age	Custody / Support	Child's Address and Telephone Number (If different from defendant)

Note health problems, criminal history, substance abuse, or any other significant information:

If applicable, describe child support, physical/legal custody and visitation issues.

What are your future plans regarding family, child care, etc.?

Is your family aware of your conviction? Yes ☐ No ☐

### PHYSICAL CONDITION/HEALTH

How would you rate your present physical health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Scars: \_\_\_\_\_ Tattoos: \_\_\_\_\_

Are any tattoos gang-related? \_\_\_\_\_

List the date(s) and nature(s) of any serious or chronic illnesses and/or medical conditions, hospitalization or surgeries.

List all current prescriptions or medications. List any allergies to food or medication.

Provide the name, address, and telephone number of your physician(s).

### MENTAL AND EMOTIONAL HEALTH

How would you rate your present mental health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Describe any past or present mental or emotional problems. Include the diagnosis of any problems (if known).

Any attempts to commit suicide:

Psychiatric treatment and/or hospitalizations:

Describe past and present gambling addiction/problem, if applicable.

Indicate if you wish to receive counseling or mental health treatment for any specific problems:

**Potential Reentry Needs:**

- ☐ State I.D.
- ☐ Social Security Card
- ☐ Birth Certificate
- ☐ Register to Vote
- ☐ Register for Selective Service
- ☐ In Need of Emergency Shelter
- ☐ Health Insurance
- ☐ Literacy Program
- ☐ Driver's License
- ☐ Passport
- ☐ Other post-release issues



### SUBSTANCE ABUSE

☐ No history of alcohol or drug abuse and/or no history of treatment for substance abuse.

Which of the following substances have you experimented with and/or abused?

- |   |   |
|---|---|
| <input type="checkbox"/> Alcohol                      | <input type="checkbox"/> Heroin/Opiates                             |
| <input type="checkbox"/> Marijuana                    | <input type="checkbox"/> Barbiturates                               |
| <input type="checkbox"/> Cocaine                      | <input type="checkbox"/> Hallucinogens                              |
| <input type="checkbox"/> Crack                        | <input type="checkbox"/> Inhalants                                  |
| <input type="checkbox"/> Amphetamine/ Methamphetamine | <input type="checkbox"/> Prescription Drugs (not prescribed to you) |
| <input type="checkbox"/> Ecstasy                      | <input type="checkbox"/> Other                                      |

When was alcohol or any controlled substance last used? \_\_\_\_\_

Which substance do you prefer? \_\_\_\_\_

Which substance has caused you the most problems? \_\_\_\_\_

Any positive urine test results: Yes ☐ No ☐

Describe your history of substance abuse and treatment. Where and When? Did you complete the program? Were you clinically discharged?

Were you under the influence of illicit substances or alcohol when the offense occurred?

Did your use of drugs/alcohol contribute to your commission of the offense? In what way?

How has your use of alcohol/drugs impacted your relationship with significant others/family?

Are you interested in receiving substance abuse treatment?

Describe your use of alcohol:

When was the first time you drank alcohol?

How often do you drink?

Drink of choice?

Did your alcohol use ever impact your life in a negative manner (employment, marital, family, legal, etc.)?

Have you ever received treatment? If yes, when, and where was the treatment facility?

### EDUCATION AND VOCATIONAL SKILLS

Highest grade completed: \_\_\_\_\_ Did you participate in special education classes? \_\_\_\_\_

### SCHOLASTIC HISTORY

Name and Location of School (List most recent school first)	Dates Attended	Degree, Diploma, or Certificate Received

Do you have any specialized training or skill(s) or hobbies?

☐ Yes

☐ No

If yes, what training or skill(s)?

\_\_\_\_\_  
\_\_\_\_\_

Do you have any professional license(s)?

☐ Yes

☐ No

If yes, what license(s)?

\_\_\_\_\_  
\_\_\_\_\_

What are your future educational goals?

☐ None

### MILITARY SERVICE

Branch of Service:	Service Number:	Entered:	Discharged:	Type of Discharge:
Highest Rank:	Rank at Separation:	Decorations and Awards:	VA Claim Number:	

Summarize your military service. Describe any courts martial or non-judicial punishments. Describe any foreign or combat service. Describe any special training or skills acquired in the service. Describe previous VA claims.

## EMPLOYMENT HISTORY

Usual Occupation: \_\_\_\_\_

Employment Status:

At present, you are:

- |   |  |
|---|--|
| <input type="checkbox"/> Employed full-time                       | <input type="checkbox"/> Employed part-time                            |
| <input type="checkbox"/> Unemployed temporarily, looking for work | <input type="checkbox"/> Unemployed seasonal worker                    |
| <input type="checkbox"/> Unemployed due to disability             | <input type="checkbox"/> Unemployed, history of extensive unemployment |
| <input type="checkbox"/> Incarcerated or confined                 | <input type="checkbox"/> Student                                       |
| <input type="checkbox"/> Homemaker                                | <input type="checkbox"/> Retired                                       |

☐ Other

(Specify): \_\_\_\_\_

## FINANCIAL CONDITION/ABILITY TO PAY

- ☐ Refer to Personal Financial and Monthly Cash Flow Statements (Forms 48 & 48B)
- ☐ Few Assets and Liabilities

## EMPLOYMENT HISTORY

(Describe your employment history for the last fifteen years)

Dates	Name and Address of Employer	Job, Monthly Wage, Reason for Leaving
From:	Phone No.:	
To Present		
From:		
To:		
From:		
To:		

<b>EMPLOYMENT HISTORY</b> (Continued)		
From:		
To:		
From:		
To:		
From:		
To:		
From:		
To:		
From:		
To:		

Summarize any employment history over 15 years old:

  
  
  
  
  
  
  
  
  
  

Is your current employer aware of your instant offense? Yes ☐ No ☐

How did you support yourself during periods of unemployment?

  
  
  
  
  
  
  
  
  
  

Describe your receipt of state/federal benefits, to include food stamps, health benefits, unemployment, social security, disability benefits, health benefits for children, etc. Also include the year(s) you received these benefits.

  
  
  
  
  
  
  
  
  
  

Describe your future employment goals/plans.

**Notes:** Is there anything else you would like the Court to know about you and your life?

**Would you be interested in any of the following?**

- ☐ Adult Basic Education Classes
- ☐ GED Prep Classes
- ☐ ESL Classes
- ☐ Computer Classes
- ☐ Vocational Programs
- ☐ College Classes
- ☐ Job Readiness Skills
- ☐ Small Business / Entrepreneurship

Prepared by \_\_\_\_\_ Date \_\_\_\_\_

Defendant 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**

- ♦ 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.

**OTHER RECORDS REQUESTED**

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**

<b>ASSETS</b>								
<b>BANK ACCOUNTS</b> (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.)								
Section A	I/J S/D	Name of Institution	Address	Type of Account	Account Number	Personal or Commercial	Balance	

  

<b>SECURITIES</b> (Include all stocks in public corporations, stocks in businesses you own or have an interest in, bonds, mutual funds, U.S. Government securities, etc.)						
Section B	I/J S/D	Name and Kind of Security	Location of Security	Number of Units	Fair Market Value	

  

<b>MONEY OWED TO YOU BY OTHERS</b> (Include all money owed to you by any person or entity.)								
Section C	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 \_\_\_\_\_

<b>Last Name -</b>								
<b>Section D</b>	<b>LIFE INSURANCE</b> (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].)							
	<b>I/J S/D</b>	<b>Name and Address of Company and Name of Beneficiary</b>	<b>Policy Number</b>	<b>Type of Policy</b>	<b>Face Amount</b>	<b>Cash Surrender Value</b>	<b>Amount Borrowed</b>	<b>Amount You Can Borrow</b>
<b>Section E</b>	<b>SAFE DEPOSIT BOXES OR STORAGE SPACE FACILITY</b> (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.)							
	<b>I/J S/D</b>	<b>Name and Address of Box or Facility Location</b>		<b>Box Number or Space</b>	<b>Contents</b>		<b>Fair Market Value</b>	
<b>Section F</b>	<b>MOTOR VEHICLES</b> (Include all cars, trucks, mobile homes, motorcycles, all terrain vehicles, boats, airplanes, etc.)							
	<b>I/J S/D</b>	<b>Year, Make &amp; License Number/Vehicle Identification Number</b>	<b>Mileage</b>	<b>Loan/Lease Balance (if any)</b>	<b>Date Loan/Lease Will be Paid Off or Ends</b>	<b>Monthly Payment</b>	<b>Fair Market Value</b>	
<b>Section G</b>	<b>REAL ESTATE</b> (Include property, parcels, lots, timeshares, and developed land with buildings.)							
	<b>I/J S/D</b>	<b>Real Estate Address (include county and state)/ Mortgage Company or Lien Holder</b>	<b>Purchase Date</b>	<b>Purchase Price</b>	<b>Mortgage Balance (if any)</b>	<b>Date Mortgage Will be Paid Off</b>	<b>Monthly Payment</b>	<b>Fair Market Value</b>
<b>Section H</b>	<b>MORTGAGE LOANS OWED TO YOU</b> (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].)							
	<b>I/J S/D</b>	<b>Mortgagee (name &amp; address)/ Relationship to Mortgagee</b>	<b>Mortgage Balance</b>	<b>Date Mortgage Will be Paid Off</b>	<b>Balloon Payment? If Yes, Date?</b>	<b>Monthly Payment</b>	<b>Is Debt Collectible?</b>	

Initials \_\_\_\_\_ Date \_\_\_\_\_

<b>Last Name -</b>								
Section I	<b>OTHER ASSETS</b> (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	<b>ANTICIPATED ASSETS</b> (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)			
	<b>TRUST ASSETS</b> (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	<b>BUSINESS HOLDINGS</b> (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

Initials \_\_\_\_\_ Date \_\_\_\_\_

<b>Last Name -</b>							
<b>Section L</b>	<b>INCOME TAX RETURNS</b>						
	<b>Type of Income Tax Return Filed</b>			<b>Last Filing Year</b>		<b>Years of Last 5 Income Tax Returns You Will Submit to the Probation Officer</b>	
	Individual (Form 1040)						
	Partnership/Limited Liability Company (Form 1065)						
	Corporation (Form 1120)						
	S Corporation (Form 1120S)						
<b>Section M</b>	<b>TRANSFER OF ASSETS</b> (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.)						
	<b>I/J S/D</b>	<b>Description of Asset/ Reason Transferred/Sold</b>	<b>Date of Transfer/Sale</b>	<b>Original Cost</b>	<b>Amount You Received, if Any</b>	<b>Name of Purchaser or Person Holding the Asset</b>	<b>Sale Price or Fair Market Value at Transfer</b>
<b>Section N</b>	<b>NAMES OF SHAREHOLDERS OR PARTNERS</b> (Include all shareholders, officers, and/or partners, indicating each respective ownership interest.)						
	<b>Name of Business</b>			<b>Names of Shareholders/Partners</b>			<b>Ownership Interest Percentage</b>

Initials \_\_\_\_\_ Date \_\_\_\_\_

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.)		

<b>Last Name -</b>							
<b>Section A</b>	<b>LIABILITIES</b>						
	<b>CHARGE ACCOUNTS AND LINES OF CREDIT</b> (Include all bank credit cards, lines of credit, revolving charge accounts, etc.)						
	<b>I/J S/D</b>	<b>Type of Account or Card</b>	<b>Name and Address of Creditor</b>	<b>Credit Limit</b>	<b>Amount Owed</b>	<b>Credit Available</b>	<b>Minimum Monthly Payment</b>
<b>Section B</b>	<b>OTHER DEBTS</b> (Include mortgage loans, notes payable, delinquent taxes, and child support.)						
	<b>I/J S/D</b>	<b>Owed To</b>	<b>Address</b>	<b>Relationship (if any)</b>	<b>Amount Owed</b>	<b>Reason Owed</b>	<b>Monthly Payment</b>
<b>Section C</b>	<b>PARTY TO CIVIL SUIT</b> (Include any civil lawsuits you have ever been a party to.)						
	<b>I/J S/D</b>	<b>Name of Plaintiff in the Case</b>	<b>Court of Jurisdiction and County</b>	<b>Case Number</b>	<b>Date of Suit Filed</b>	<b>Date of Judgment</b>	<b>Judgment Amount/ Unpaid Balance</b>
<b>Section D</b>	<b>BANKRUPTCY FILINGS</b> (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.)						
	<b>I/J S/D</b>	<b>Type of Bankruptcy (Voluntary or Involuntary)/ Name and Address of Trustee</b>	<b>Bankruptcy Case Number</b>	<b>Bankruptcy Court of Jurisdiction</b>	<b>County and State of Discharge</b>	<b>Date Filed</b>	<b>Date of Discharge</b>

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.

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

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

Signature \_\_\_\_\_

Date \_\_\_\_\_

**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 \_\_\_\_\_, \_\_\_\_\_.

**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)



**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)

# **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

**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: [adulthoodinfo@doe.state.nj.us](mailto:adulthoodinfo@doe.state.nj.us)

Website: [www.state.nj.us/education/students/adulthood](http://www.state.nj.us/education/students/adulthood)

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 <b>High School Equivalency Access Code</b> to me. It is my understanding that the <i>E-Transcript/Diploma Verification</i> serves as the <i>Official Transcript of High School Equivalency Test Results/Official Diploma Verification</i> . This Official document contains a unique <i>Verification Code</i> . 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: [adulthoodinfo@doe.state.nj.us](mailto:adulthoodinfo@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.

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

Date : \_\_\_\_\_



**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)
<i>WITNESS:</i> _____ (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

**CONFIDENTIAL****RECORDS REQUEST FORM**

(Revised: 12/6/18)

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.



REALIZING POTENTIAL & CHANGING FUTURES

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**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)**

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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> EMERGENCY ROOM RECORD       | <input type="checkbox"/> CONSULTATIONS       | <input type="checkbox"/> COMPLETE RECORD |
| <input type="checkbox"/> HISTORY & PHYSICAL EXAM     | <input type="checkbox"/> PROGRESS NOTES      | <input type="checkbox"/> ABSTRACT        |
| <input type="checkbox"/> OPERATIVE REPTS & PATHOLOGY | <input type="checkbox"/> LAB, X-RAYS & TESTS | <input type="checkbox"/> AUTOPSY REPORT  |
| <input type="checkbox"/> DISCHARGE SUMMARY           | <input type="checkbox"/> NURSES' NOTES       | <input type="checkbox"/> 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: \_\_\_\_\_



**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: \_\_\_\_\_



☐ **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](http://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:
<b>1. Type of Request:</b> I hereby request the following: <input type="checkbox"/> Access to review my original medical record <input type="checkbox"/> Release/Disclosure of my health information, as requested below <input type="checkbox"/> Request my medical records from another facility <i>Name of Facility:</i> _____			
<b>2. Description of Information To Be Released:</b> <i>(Check ALL that apply)</i> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Abstract* (defined below)      <input type="checkbox"/> Entire Medical Record  <input type="checkbox"/> Immunization Record      <input type="checkbox"/> ER Record  <input type="checkbox"/> Outpatient Records      <input type="checkbox"/> Consultation Reports  <input type="checkbox"/> Treatment Record      <input type="checkbox"/> Labs         </div> <div style="width: 50%;"> <input type="checkbox"/> History and Physical      <input type="checkbox"/> Operative Reports  <input type="checkbox"/> Progress Notes      <input type="checkbox"/> X-ray Reports  <input type="checkbox"/> EKG/EEG      <input type="checkbox"/> Discharge Summary  <input type="checkbox"/> Other (specify): _____         </div> </div> Date of Service: _____ <i>(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, test results)</i>			
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.			
<b>3. Disclose/Send Information To:</b> <input type="checkbox"/> Myself <i>(the patient or authorized representative)</i> <input type="checkbox"/> To Organization/Individual below:			
Organization:		Individual Name:	
Street Address:		City:	State:      Zip Code:
			<input type="checkbox"/> Please Mail <input type="checkbox"/> Please Fax: _____ <input type="checkbox"/> Please prepare for pick-up
<b>4. Purpose of Release:</b> I authorize Capital Health to release my health information for the following specific purpose: _____			
<b>5. Term/Expiration:</b> 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>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.</i>			
<b>6. Fees:</b> 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 \_\_\_\_\_

<input type="checkbox"/> Admission Record	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> AIDS or HIV-related information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> X-Rays	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Emergency Department Record	<input type="checkbox"/> Laboratory Results	
<input type="checkbox"/> History and Physical Consultation(s)	<input type="checkbox"/> Psychiatric Records	
<input type="checkbox"/> Pathology Report(s)	<input type="checkbox"/> Drug abuse and/or alcoholism treatment records	
<input type="checkbox"/> 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: \_\_\_\_\_

## 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