MOORESTOWN VISITING NURSE ASSOCIATION / PARTNERS IN HOME CARE
THE HOSPICE OF MOORESTOWN VNA
300 Harper Drive, Moorestown, NJ 08057 ♦ Tel: (856) 552-1300 Fax: (856) 552-1301

AUTHORIZATION FOR RELEASE OF INFORMATION

Fax to: (856) 552-1303

Patient Name: _____ **ID Number:** _____

Person/Organization authorized to provide the information:
Moorestown Visiting Nurse Association _____

Person/Organization authorized to receive the information:

_____

_____

Specific description of information authorized for release: [include date(s)]

_____

_____

_____

Purpose of information: (if other than "at my request", describe)

□ At my request: _____

Other:

_____

_____

Expiration date for authorization: (if any) _____ ☐**None**

Statement of Authorization:

I hereby authorize the use and/or disclosure of my identifiable health information as described above. I have been informed and understand the following:

1. I have a right to revoke this authorization by notifying the providing person/organization in writing, and that if I do revoke the authorization it will only affect release of further information. It will not apply to information already released.
2. I understand that there is a potential for the information authorized to be subject to disclosure by the recipient, and in some cases, will no longer be protected health information.
3. I understand that my health care will not be affected if I do not sign this authorization.

_____ _____

(Signature of Patient or Patient's Legal Representative) (Date)

_____

Description of Legal Representative's Authority

****** Must include a copy of Legal Representative Authority***

A copy of this authorization will be mailed to the patient.

Return this signed and completed form to:
Moorestown Visiting Nurse Association, Medical Records Department, 300 Harper Drive, Moorestown, NJ 08057.