

**Records Release Authorization
(Obtain Information)
At the Request of the Patient**

Client Name: _____ DOB: _____

Telephone Number: _____ Cell Phone Number: _____

I, I _____ hereby authorize:

The Community Counseling Center of Moorestown VNA
300 Harper Drive, Moorestown, NJ 08057 Phone: 856-380-1070 Fax: 856-552-1315

II. To obtain the following information:

- | | | | |
|-----------------------------------|------------------------------|-------------------------------|------------------------|
| Comprehensive Eval | Medical History | Drug/Alcohol History | Psychological Tests |
| Treatment Plans | Diagnosis | Admission Records | Service History |
| Medication History | Social Work Assessment | Attendance Record | Psychiatric Evaluation |
| Summary of Treatment/
Progress | HIV/AIDS Laboratory
Tests | Attendance and
Cooperation | Psychiatric History |
| Prescription Record | | | Other _____ |

This information is being **obtained** from:

Person's Name: _____

Telephone #: _____ Fax #: _____

Organization: _____

Street Name: _____

City, State, Zip: _____

III. The purpose for this released information is: At the request of the patient

Other: _____

The authorization for this release expires sixty (60) days after discharge.

I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that action has been taken in reliance thereon. In order to revoke this Authorization, I understand that I must revoke it in writing to The Community Counseling Center of Moorestown VNA.

I understand that The Community Counseling Center of Moorestown VNA may not require that I sign this Authorization in order to obtain treatment.

I have read this authorization and have had a chance to ask questions about the use and disclosure of my medical information. By signing below, I voluntarily authorize The Community Counseling Center of Moorestown VNA to release my information in the manner described above.

Signature of Client, client's parent and/or guardian

Date

Witness

Date CCC/Licensure/Originals/OBTAIN/Request of Patient Nov 2017