THE COMMUNITY COUNSELING CENTER OF MOORESTOWN VNA

Records Release Authorization (Forward Information) Continuity of Care

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 release 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 released to:**

Person's Name: ____

Telephone #: _______________________ **Fax #:**_________________________

Organization: ____

Street Name: ____

City, State, Zip: ____

III. The purpose for this released information is: **[X] Continuity of Care**

[ ] 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 understand that information disclosed under this Authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to privacy protections provided to me by law.

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