COMMUNITY HEALTH CENTER
Visiting Nurse Association of Central Jersey

| | |
|---|---|
| Patient Name: | AKA: |
| Date of Birth: | Social Security #: |
| Address: | |

I hereby authorize Visiting Nursing Association of Central Jersey Community Health Center, Inc. (CHC) to:

☐ Release Information to or ☐ Obtain Information from

| |
|---|
| Name/Facility: |
| Address: |
| City, State, Zip: |
| **Fax #:** |

I understand that authorizing the disclosure information is voluntary and I do not have to sign this form in order to receive treatment from CHC. I also understand that information that is used and/or disclosed pursuant to this authorization may not be protected from re-disclosure by the recipient unless the recipient is covered by New Jersey law or other laws that prohibit the re-disclosure of such information. I understand that I will be given a copy of this form after I sign it.

1. Description of information to be used/disclosed (includes date of service):

For the Purpose:

*Note: I specifically authorize the use and/or disclosure of the following type of highly confidential information* ***indicated by my initials*** *next to the information type:*

____Treatment for alcohol and/or drug use ____Behavioral or mental health disorders ____Genetic
____Sexually transmitted disease(s) ____Tuberculosis ____AIDS/HIV

2. Expiration of Authorization: I understand that I have the right to revoke this authorization at any time by submitting a written revocation to the following address: the Privacy Official, 1301 Main Street, Asbury Park, NJ 07712. I understand however, that such revocation will not apply to actions CHC takes in reliance on the authorization before the revocation of authorization is received. Unless otherwise revoked, this authorization will expire on the following date_____ or upon the following event: _____. If not date or event is specified, this authorization will expire in one year from the date signed.

| | |
|---|---|
| Signature of patient or authorized representative: | Date: |
| Print Name: | |
| Signature of Witness: | Date: |
| Print Name: | |
| If signed by authorized representative, print authorized representative's name and describe legal authority to act on patient's behalf | |

**Send completed, signed authorization to: Freehold Family Health Center: 597 Park Ave, Freehold, 07728**
**Telephone: 732-294-2540 Fax: 732-294-9328**

Notice to Recipient: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. Pursuant to federal rules (42 CFR, Part 2), you are prohibited from making further disclosure of alcohol or drug abuse patient records unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or as otherwise permitted by.