

Release of Information Authorization – Emergency

I, _____, DOB _____, SS# _____,

do hereby consent and authorize my therapist: Theresa Wray LCSW LCADC and Live Well Counseling and Training, LLC (2021 New Road; Unit 10, Linwood NJ 08221, Phone: 609-206-7435) to release or obtain the belownoted information to and from:

- Shore Memorial, 100 Medical Center Way, Somers Point, NJ 08244, Phone 609-653-3500
- AtlantiCare Mainland, 65 W. Jimmie Leeds Road, Pomona NJ 08205 Phone 609-652-1000
- AtlantiCare City, 1925 Atlantic Avenue, Atlantic City, NJ 08401, 609-345-4000
- Somers Point Police, 1 W New Jersey Ave # 2, Somers Point, NJ 08244, (609) 927-6161
- Local Ambulance Squad

The information that may be released is limited to the minimum necessary and may include the following:

- Presence in treatment (admission/discharge dates)
- Presence in treatment letter
- Diagnoses
- Brief description of progress and prognosis
- Psychosocial/diagnostic summary
- Emergency information
- Medical history and physical examination
- AIDS/HIV and communicable disease information
- Other (specify): _____
- Treatment plan and treatment plan updates
- Discharge/continuing care plan
- Legal history/current legal status
- Physical description
- Medical records (EKG, X-ray, lab results)
- Psychiatric/Psychological assessments
- Medications (refills, doses, frequencies)
- Urine drug screen/breathalyzer results

Reason(s) for disclosure: Coordination of Care / Continuity of Care

I understand that I am not required to consent to the release of information and that I do so voluntarily for the purposes stated above. This authorization will remain in effect for no longer than one (1) year from the date signed unless an earlier expiration date, event, or condition is specified below. I understand that I may revoke this authorization at any time by notifying my therapist, Live Well Counseling and Training LLC, in writing, except to the extent that action has already been taken in reliance on this authorization.

Specific date, event, or condition upon which this authorization shall expire:

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

Patient was offered a copy of this authorization: Received Declined

PROHIBITION OF REDISCLOSURE: This information has been disclosed from records protected by federal confidentiality laws, including 42 CFR Part 2. Federal regulations prohibit further disclosure of this information without the specific written consent of the individual to whom it pertains, unless otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient. These regulations restrict the use of this information to criminally investigate or prosecute any individual for substance use-related conditions.