**Core Counseling South Jersey, LLC**

**Phone: (856) 866-6331 Fax: (856) 772-9674**

**1000 White Horse Road, Suite 904**

**Voorhees, NJ 08043**

**AUTHORIZATION TO RELEASE & EXCHANGE INFORMATION (ROI)**

**Client:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Attn:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_          **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

      (Client/Guardian Name)                        (Agency or Person Releasing/Exchanging Information to Core Counseling South Jersey) to exchange information with Core Counseling South Jersey, LLC.

**Purpose(s) or need for which information is to be used:**

Continuity of Service                    Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be Released:**

\_\_ Presence in Treatment      \_\_ Educational Information      \_\_Psychiatric History

\_\_Verbal and Written Progress     \_\_ Psychological Evaluation     \_\_ Medication History

\_\_Treatment Plan/Recommendation    \_\_Probation/Parole Conditions   \_\_Psychosocial History

\_\_ Copy of Aftercare Plan  \_\_ Financial Information

\_\_ Physician's Orders   \_\_Discharge Summary    \_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that information to be released may include information regarding the following:**

\_\_Chemical Abuse and/or Dependency    \_\_Psychiatric Conditions   \_\_ \_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPORTANT NOTE:** If the information to be released pertains to the diagnosis and treatment of alcoholism and/or drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42 C.R.S. Part 2. Authorization: I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it. I understand that this consent will expire upon termination of therapy or upon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I hereby release any service provider or individual from any liability, which may result from furnishing the information requested as authorized in this release. Redisclosure of my medical records may not be accomplished without further written consent. A COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

**Client Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_

**Therapist Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Therapist Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_