J&T Behavioral Health and
Counseling Services

700 Liberty Place
Sicklerville, NJ 08081
Tel: 856-776-7540
Fax: 856-776-7512

Authorization to Obtain Information

Patient Name: _____
Date of Birth (DOB): _____
SS#: _____
Date: _____

I, _____, hereby authorize J&T Behavioral Health and Counseling Services.

Address: 700 Liberty Place, Sicklerville, NJ 08081
Phone: (856) 776-7540
Fax: (856) 776-7512

Information Requested

To obtain the following information (please check all that apply):

☐ Mental Health History
☐ Substance Abuse History
☐ Medical History
☐ Treatment Plans
☐ Diagnosis
☐ Attendance/Participation
☐ HIV/AIDS
☐ Appointment Information
☐ Admission Records
☐ Medication History

☐ Psychiatric Evaluation
☐ Service History
☐ Summary of Treatment/Progress
☐ Other (specify): _____
☐ Other (specify): _____
☐ All of the Above Information

Information Source

This information is to be obtained from: _____

Phone: _____
Fax: _____

This information is to be obtained by: _____

Authorization Terms

I understand that this information shall be in effect for **90 days following the date of signature**. However, I understand that this authorization may be revoked at any time by giving oral or written notice to J&T Behavioral Health and Counseling Services.

A photocopy of this authorization shall constitute a valid authorization. I understand that once my records have been discussed, J&T Behavioral Health and Counseling Services cannot retrieve them and has no control over the use of already released copies.

I hereby allow J&T Behavioral Health and Counseling Services to discuss and release records from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a governing agency or another medical professional actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted for review.

My signature below is proof that I have read and/or had read to me the nature of this authorization. I am aware that any of the above information may be released via verbal communication, written documents, and/or fax. I understand that this authorization is **voluntary** and **not a condition for treatment**.

Signatures

Patient/Responsible Party Signature: _____
Date: _____

Witness: _____

Notice

The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the person to whom it pertains.