Public Health
Prevent. Promote. Protect.

Department of: HEALTH

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Board of Chosen Freeholders
County of Burlington
New Jersey

Physical Address:
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Westampton, NJ 08060

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P.O. Box 6000
Mount Holly, NJ 08060-6000

MEDICAL NEEDS SHELTER RELEASE OF INFORMATION AND CONSENT FOR TREATMENT

Client Name: _____

Address: _____

Phone: _____ **Date of Birth**: _____

Medical Needs Shelter Location: _____

Name and Address of Legal Guardian (if applicable): _____

_____

CONSENT FOR SERVICE/TREATMENT:
The Information contained herein is true and correct to the best of my knowledge.
The extent of services available at the Medical Needs Shelter has been explained and I understand the limitations of those services and level of care available.
I understand that assistance will be provided only for the duration of the emergency.
I hereby authorize the Burlington County Health Department (BCHD) and its medical providers, nurses, and other Professional staff, and volunteers to provide care as appropriate and to disclose necessary medical information to other providers as required for the continuity of my care.

I voluntarily authorize BCHD, including its employees and agents, to disclose information to the following individuals:

_____
_____
_____

This authorization shall be effective during my stay in the Burlington County Health Department Medical Needs Shelter.
Applicant Name (PRINT): _____
Applicant Signature: _____ **Date**: _____
Name of person filling out the application if different than applicant:
_____
Relationship to applicant: _____
Signature: _____ Date: _____