CHILD & FAMILY COUNSELING CENTER

PATIENT UPDATE FORM
2022

PLEASE COMPLETE ALL THE FOLLOWING SO WE MAY KEEP YOUR RECORDS UPDATED
THANK YOU VERY MUCH!

DATE:_____

Patient Name_____DOB:_____

Responsible Party_____DOB:_____

Address_____

City_____State_____Zip_____

Phone (Home)_____Cell_____

Work_____

Current Insurance Company:_____

Name of Policy Holder:_____

Policy Holder D.O.B._____

Pharmacy Name:_____

Pharmacy Phone:_____Pharmacy Zip Code_____

Primary Care Doctor Name_____

Phone #_____

PLEASE GIVE INSURANCE CARD TO RECEPTIONIST TO BE COPIED.

CHILD AND FAMILY CFCC COUNSELING CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_____ Date of Birth _____

___ I authorize:
___ I do **NOT** authorize

Child and Family Counseling Center
13649 Office Place, Ste. 102
Woodbridge, VA 22192

___ to exchange with ___ to disclose to ___ to obtain from

Name(s)_____

Address _____

Fax/Phone Number_____
The following information:

___ medical records
___ educational records
___ psychiatric evaluation
___ psychological evaluation
___ Neurological evaluation
___ ongoing verbal/written communication
___ laboratory reports
___behavioral report
___ teacher report
___ treatment/discharge summary
___ other information (below)

Approximate dates of service:_____

For the purpose of :____ facilitation treatment ___ emergencies only ____court report

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below.

I allow the listed agency to accept a copy of this form as a valid consent to release information. This consent includes information which is placed in the record after the date this consent was signed, unless noted otherwise.

This consent expires on the date the chart is closed OR as specified her on/when _____

_____

_____
Client or Parent signature Date Witness Signature