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

____

____

____

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 : ____ facilitating 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 here on/when______________
____

______________________________ ______________ ________________________
Client or Parent Signature Date Witness Signature (2-9-11)

13649 Office Place, Suite 102 • Woodbridge, Virginia 22192 • 703/670-5738 • Fax 703/670-8213