



**AUTHORIZATION FOR RELEASE OF INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize: Child and Family Counseling Center  
13649 Office Place, Ste. 102  
 I do NOT authorize Woodbridge, VA 22192

\_\_\_\_\_ to exchange with \_\_\_\_\_ to disclose to \_\_\_\_\_ to obtain from  
\_\_\_\_\_  
\_\_\_\_\_

the following information:

- |   |  |
|---|--|
| <input type="checkbox"/> medical records                      | <input type="checkbox"/> laboratory reports          |
| <input type="checkbox"/> educational records                  | <input type="checkbox"/> behavioral report           |
| <input type="checkbox"/> psychiatric evaluation               | <input type="checkbox"/> teacher report              |
| <input type="checkbox"/> psychological evaluation             | <input type="checkbox"/> treatment/discharge summary |
| <input type="checkbox"/> neurological evaluation              | <input type="checkbox"/> other information (below)   |
| <input type="checkbox"/> ongoing verbal/written communication | _____  |

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)