

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:

- | | |
|--|---------------------------------|
| ___ medical records | ___ laboratory reports |
| ___ educational records | ___ behavioral report |
| ___ psychiatric evaluation | ___ teacher's report |
| ___ psychological evaluation | ___ treatment/discharge summary |
| ___ neurological evaluation | ___ other information (below) |
| ___ 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 one year after this consent was signed OR as specified here on/when _____

Client or Parent Signature _____ Date _____ Witness Signature _____ (4-09)