8140 Ashton Avenue
Suite 200
Manassas, Virginia 20109
703.330.9933 Fax 703.686.4319

12721 Darby Brooke Court
Suite 102
Woodbridge, Virginia 22192
703.497.1771 Fax 703.497.1225

Release of Information

Patient's Name:______________________________ Phone:______________ DOB: __________________

Address:______________________________ City:_________ State:______ Zip: ___________

I,____, authorize_______________________________________ to:

Patient Name/Guardian Clinician/Practice Name/Other

______ (send)______ (receive) from ____ of

Clinician/Practice Name/Other

____

(Please Provide the name, address and phone number of the person who will be receiving the information)

Please initial all and any that apply:

_______ Verbal exchange ______ School Records ______Psychological Testing Reports
_______ Academic Reports ______Treatment/Service Plans ______Summary reports
_______ IEP/504 Plans ______Medical Records ______Other, specify: ______________________

The above information will be used for the following purposes:

___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Determining eligibility for benefits or program6060
___ Case review ___Updating files
___ Other (specify) ____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: Self Parent/legal guardian Personal representative Other (describe)

____

Patient's/Guardian/Personal Representative Signature:________________________________Date: ___________

Witness: ___________________________________ Date: ______________