Client: _____
ID:_____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ DOB _____

I hereby give permission for Counseling Alliance of VA, LLC and their clinicians to exchange information with:

Name:_____ Phone #: _____-_____-_____

Address: _____ FAX #: _____-_____-_____

_____

The information to be disclosed includes:

__ Psychological Reports __ Medical Reports __ Psychiatric Reports

__ Court Records __ School Records __ Other_____

This authorization will expire on _____/_____/_____

I understand that I have the right to revoke this authorization by requesting it be revoked in writing. However, I also understand that once information is disclosed to a second party it might be subject to re-disclosure by that party; in that case I would not be protected by being able to revoke the authorization.

I understand this to be professional and confidential information and that it may be communicated in written and/or oral form.

I understand that I have the right to refuse to sign this authorization.

_____ _____
Responsible Party/Legal Guardian (Signature) **Name (Print)**

_____
Address

_____ _____
City State Zip code **Date**

_____ _____
Witness (Signature) Date **Staff Signature**

Counseling Alliance of Virginia, LLC
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