CLIENT: _____
#: _____

AUTHORIZATION FOR RELEASE OF 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**

Counseling Alliance of Virginia, LLC

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