Renewing Hearts Family Counseling

Authorization for Release of Information

Patient's Name: _____ Date of Birth:_____

___I authorize
___ I do not authorize

Renewing Hearts Family Counseling
13895 Hedgewood Dr Suite 229
Woodbridge, VA 22193

___ to exchange ___ to disclose to ___to obtain from
_____
_____
_____
_____

The following information:

___ medical records
___ educational records
___ diagnoses
___ psychiatric evaluation
___ psychological evaluations
___ neurological evaluations
___ ongoing verbal/written communication
___laboratory reports
___ behavioral reports
___ psychosocial reports
___ progress reports
___ teacher reports
___ treatment/discharge summary
___ other _____

Approximate date of service:_____

For the purpose of ___ facilitating treatment ___ emergencies only ___ court report

I understand that I may revoke this consent at my 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