



Release of Information

Patient Name: _____ Date of Birth: _____

Primary Phone #: _____ Email: _____

Release Purpose: (Check all that apply):		Person or Organization:	
<input type="checkbox"/> Release Information <input type="checkbox"/> Receive Information <input type="checkbox"/> Verbally or Electronically Exchange Information Child & Family Counseling Group, P.L.C.		Name of Person or Organization: _____	
Address: 10521 Rosehaven Street, Suite 100		Address: _____	
Fairfax, VA 22030		City, State, Zip: _____	
Phone: 703-352-3822 Fax : 703-385-8353		Phone # _____ Fax # _____	
Information Category (Check all that apply):			
<input type="checkbox"/> Billing Information		<input type="checkbox"/> Behavioral Report	
<input type="checkbox"/> Education/Academic Records		<input type="checkbox"/> Psychological or Neurological Evaluation	
<input type="checkbox"/> Progress Notes		<input type="checkbox"/> Psychiatric Records	
<input type="checkbox"/> Teacher's Report			
<input type="checkbox"/> Other (please specify): _____			
<input type="checkbox"/> Entire Medical Record for Specified Date Range: _____ to _____			
Purpose of Release			
<input type="checkbox"/> Legal		<input type="checkbox"/> Transfer of care	
<input type="checkbox"/> Continuing Care		<input type="checkbox"/> Other (Please Specify): _____	
<input type="checkbox"/> School			
Authorization For General Release of Information			
I authorize Child & Family Counseling Group, P.L.C. to release, receive or exchange information from the above-mentioned patient's medical record as stated. You may amend or revoke this form in writing to Child & Family Counseling Group, P.L.C.			
**NOTE: Please complete form in its entirety, failure to do so may delay or deny processing of your request. Release expires 1 year from date signed unless otherwise stated here: _____			

 Print Patient Name:

 Patient Signature:

 Parent/Guardian Signature: (If under 18)

 Date: