CHILD & FAMILY COUNSELING GROUP
*Comprehensive Diagnostic & Therapeutic Services*

**Authorization for Release of Information**

Patient Name:_____ Date of Birth: _____

Phone #: _____

| Child & Family Counseling Group: (Check all that apply): | Outside Person or Organization: |
|---|---|
| ☐ Release Information<br>☐ Receive Information<br>☐ Verbally or Electronically Exchange Information<br>**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 to Be Released (Check all that apply):** | |
| ☐ Billing Information | ☐ Behavioral Report |
| ☐ Education/Academic Records | ☐ Psychological or Neurological Evaluation |
| ☐ Progress Notes | ☐ Psychiatric Records |
| ☐ Teacher's Report | |
| ☐ Other (please specify): | |
| ☐ Entire Medical Record for Specified Date Range:_____to _____ | |
| **Purpose of Release:** | |
| ☐ Legal | ☐ Transfer of care |
| ☐ Continuing Care | ☐ Other (Please Specify): |
| ☐ 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.**<br><br>***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:*** _____ | |

_____ _____

**Patient Signature** **Date**

_____

**Parent or Guardian Signature (if patient is under 18)**