CFCG ~ **THE CHILD & FAMILY COUNSELING GROUP, P.L.C.**

Comprehensive Diagnostic & Therapeutic Services

Authorization for Release of Information

Patient Name: _____ **DOB:** _____

I authorize (CFCG Provider Name): _____

The Child & Family Counseling Group, P.L.C.
10521 Rosehaven Street - Suite 100
Fairfax, Virginia 22030

_____ To exchange information with

_____ To release to

_____ To receive from

Name of Person, Organization or Institution: _____

Address: _____

Phone: _____ Fax: _____

The following information:

____ Medical Records
____ Education/Academic Records
____ Psychiatric Records
____ Psychological Evaluation
____ Neurological Evaluation
____ Behavioral Report
____ Teacher's Report
____ Verbal Exchange
____ Other Information
(Please Specify)

_____
_____

Approximate Dates of Service: _____

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PARENT/GUARDIAN SIGNATURE (if under 18) DATE

_____

PRINT PATIENT NAME Release Expiration Date: _____