New Beginnings Family Counseling Services

911 East Jefferson Street Charlottesville, va 22902 Phone: (434)984-0023

**Release of Confidential Information Authorization**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give permission to New Beginnings Family Counseling Services, Inc, to release and/or receive confidential information with:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information to be disclosed includes (check all that apply):

\_\_\_\_\_\_\_\_Medical Reports \_\_\_\_\_\_\_\_\_\_School Records

\_\_\_\_\_\_\_\_Psychiatric Records \_\_\_\_\_\_\_\_\_\_Psychological reports

\_\_\_\_\_\_\_\_Court records \_\_\_\_\_\_\_\_\_\_Other:

\_\_\_\_\_Written information, including, but not limited to assessments, ISPs, quarterly reports, and discharge summaries.

\_\_\_\_\_Verbal information to coordinate with other therapist or involved agency to discuss case planning and management

I understand that I have the right to revoke this authorization at any time by doing so in writing, except to the extent that information has already been released pursuant to the original release.

I understand that I have the right to refuse to sign this authorization.

Print Name Signature of Person Authorized to Consent Date of Signing

\*If no date is stated, expiration date is one year from the signature date \_\_\_\_\_\_\_\_\_.