AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Virginia Counseling Associates, LLC by other individuals or agencies. Such requests should be referred to the original individual or agency.

I ____ authorize Virginia Counseling Associates, LLC to:

_____ release to:
_____ obtain from:
_____ exchange with:

____
____
____
____

the following information pertaining to:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _______________________________

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _______________________________

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event __________________ ____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

____
Signature of Client Date

Social Security #:________________
OR
Date of Birth:___________________

____
Signature of Witness Date

VIRGINIA COUNSELING ASSOCIATES

RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

_____ 6 months OR

_____ other (specify) ______________________________

____ ____________________________________

Client Date Witness Date

Check One:

_____ 6 months OR

_____ other (specify) ______________________________

____ ____________________________________

Client Date Witness Date

Check One:

_____ 6 months OR

_____ other (specify) ______________________________

____ ____________________________________

Client Date Witness Date