Family Therapy Center of Northern Virginia, llc
44081 Pipeline Plaza #225, Ashburn, VA 20147

Release of Information

I _____and/or _____
Client Name and Date of Birth *Parent/Guardian*

authorize _____ to _____obtain and/or _____ release to/from:
(clinician)

_____ _____
Organization and/or Individual's Name *Relationship to Client*

_____
Street address *City* *State* *Zip Code*

_____ _____
Phone Number *Fax Number/E-mail*

The purpose of this release is: _____

Information that may NOT be disclosed: _____

_____

I understand that this information is protected under Federal and State confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand that this ***release expires 90 days after the end of the continuum of treatment*** *unless otherwise noted. I further acknowledge that the information to be released was fully explained and that this consent was given of my own free will. This consent includes information placed in my records after the date of signature below.*

_____
Client's Signature Date

_____
Parent/Guardian's Signature Date

_____
Clinician's Signature Date

Note, where information accompanies this disclosure form: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.