Authorization to Release Information

•14900 Bogle Drive, Suite 200 • Chantilly, VA 20151-1652 • 703-817-9890 • FAX 703-817-9860 • www.fcsva.org•

I _____ (hereinafter "Patient") hereby authorize For Children's Sake of VA therapist _____ (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to: _____

_____

- I understand that I have a right to receive a copy of this authorization.
- I understand that any cancellation or modification of this authorization must be in writing.
- I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it.
- I also understand that such revocation must be in writing and received by Provider at the address or via fax using the contact information listed above in order to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose(s): _____

_____

_____

The specific uses and limitations of the types of medical information to be discussed are as follows **(be as specific as you choose to be):** _____

_____

_____

Such disclosure shall be limited to the following specific types of information: _____

_____

_____

_____

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Virginia law may protect such information.

This authorization shall remain valid until: _____

_____ Date: _____

Patient's signature

_____ Date: _____

Parent/Guardian of Minor Patient: