

Authorization to Release/Disclose Health Care Information

Name of Patient (Please Print) _____

Date of Birth: _____

I hereby authorize:

Name: _____

Address: _____

Email Address: _____

Telephone #: _____ Fax #: _____

to release reciprocally copies of the following confidential information which may include alcohol and substance abuse information and/or abstract information, this includes medical, psychiatric and/or psychological information that may be protected under HIPAA.

TO: Robyn E. Brickel, M.A., LMFT, LLC
300 North Washington Street
Suite # 305, Alexandria, VA 22314

I specifically authorize release of the following information:

- _____ Medical History/Intake Evaluation
 - _____ Progress Notes
 - _____ Consultation Reports or Notes
 - _____ Verbal Discussion of Case
 - _____ Other: _____
- _____

The requested records or information is about health care provided during the following approximate time frame:

You have the right to withdraw your consent for release of information at any time with written notice to the office of Robyn E. Brickel, M.A., LMFT, LLC.

I have read the above statement. I understand that the materials being released/requested will be kept strictly confidential. Information may only be used for the development of/continued therapeutic treatment and no one other than the above parties may have access.

(Signature of client or parent/guardian)

Date: _____

(Signature of client or parent/guardian)

Date: _____

(Witness)

Date: _____
