Behavior Works of Virginia, LLC

Mailing address: 312 Granite Avenue Richmond, VA 23226

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

_____ _____

Client's Last Name, First, Middle Date of Birth

_____ _____

Street Address City State Zip

_____

Telephone Number

I authorize use or disclosure of the above named individual's health information as described below:

The following provider is authorized to disclose my health information: _____

Information to be released:

- □ Entire record
- □ Discharge summary
- □ Other: _____

I authorize use or disclosure of the health information of the above named individual for the purposes of:

- □ At the request of the individual
- □ Coordination of treatment
- □ Other: _____

This information may be disclosed to the following individual or organization:

_____

Name

_____

Address

_____

Telephone

If I check the following box, the individual or organization named above may also disclose information to _____for the purposes described above. □

As the person signing this consent, I understand that I am giving permission for _____ to disclose confidential information or records. I also understand that I have the right to revoke this consent at any time, but that my revocation is not effective until it is delivered in writing to Dr. Farrell-Carnahan. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made will be included in my original records.

_____ _____

Print client's name *Print legal guardian/parent name if client is a minor*

_____ _____

Signature of client/legal guardian/parent *Date*