Beach Counseling Center LLC

Authorization to Release or Receive Confidential Information

(Please circle one)

Name _____ DOB: _____

Address: _____

City _____ State _____ Zip _____

I hereby authorize:

Beach Counseling Center LLC
1064 Laskin Road, Suite 14C
Virginia Beach, VA 23451

or

1009 Frederick Road
Catonsville, MD 21228

To release or receive my health information to/from: (please circle one)

Doctor/Counselor/Teacher _____

Street Address: _____

City _____ ST _____ ZIP _____

Telephone _____ Fax _____

Specific type of information to be disclosed:

- ☐ Initial Evaluation
- ☐ Medications Record
- ☐ Alcohol/Drug Treatment Records
- ☐ Records from _____ to: _____
- ☐ Psychological Evaluation Results
- ☐ Discharge Summary
- ☐ Other _____

The purpose or need for such disclosure:

- ☐ Continuity of care
- ☐ Court related issue
- ☐ Disability/Life Insurance
- ☐ Complete referral
- ☐ Discharge & follow-up planning
- ☐ Other _____

Method of transmission: ☐ Written information ☐ Telephone ☐ Fax

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that any information released prior to my revoking this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke the authorization prior to such time, this authorization shall expire 365 days from today's date. I understand the fee of

Client Signature _____ Date _____

Legal Guardian or Parent _____ Relationship to patient _____

Witness _____ Date _____