10 Basil Sawyer Dr.
Suite A
Hampton, VA 23666

Associated Counselors of Tidewater, Inc.

Phone: (757)490-6960 Fax: (757) 490-6995

287 Independence Blvd.
Pembroke Two, Suite 219
Virginia Beach, VA 23462

RELEASE OF INFORMATION AUTHORIZATION

Client's name: _____

Date of Birth: _____ SSN#: _____

Parent/Guardian's name (if client is a minor): _____

Therapist's name at Associated Counselors of Tidewater: _____

My signature authorizes Associated Counselors of Tidewater to: (initial next to each one below)

obtain information from the following company/person _____
release information to the following company/person _____
have verbal contact with the following company/person _____

Company Name: _____

Person's Name: _____

Address: _____

Phone number: _____ Fax number: _____

Information requested and/or to be released:
___ Any & All confidential psychological/psychiatric, and account information discussed with the therapist or on file including everything listed below
Limited Information: (initial next to each one below that you want included)
___ Dates of Treatment
___ Insurance/EAP Information
___ Account/Financial Information
___ Appointment/scheduling Information
___ Diagnosis ___ Treatment Plan ___ Prognosis ___ Progress to Date
___ Client Questionnaires
___ Tests Results
___ Summary of Treatment
___ Progress Notes (***this is normally only release with a court order)
___ Other information to be released: _____

I understand that this form or the information being exchanged may be transmitted by fax or email.
I understand that federal or state law may protect certain records/information and I am requesting that any and all such protected records/information be disclosed under this authorization.
I understand that this release of information authorization expires twelve months from the date of signature, and may be revoked at any time with written notification.

_____ _____
Signature of Client, Parent, or Guardian Date

_____
Signature of Witness