CFCG ~ THE CHILD & FAMILY COUNSELING GROUP, P.L.C.
Comprehensive Diagnostic & Therapeutic Services

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____

DOB: _____

I authorize: _____

The Child & Family Counseling Group, P.L.C.
3959 Pender Drive, Suite 320
Fairfax, Virginia 22030

_____ to exchange information with

_____ to release to

_____ to receive from

_____
NAME OF PERSON, ORGANIZATION, OR INSTITUTION

_____
ADDRESS

The following information:

_____ Medical Records
_____ Education/Academic Records
_____ Psychiatric Records
_____ Psychological Evaluation
_____ Neurological Evaluation
_____ Behavioral Report
_____ Teacher's Report
_____ Verbal Exchange
_____ Other Information

Approximate Dates of Service: _____

For the Purpose of: _____

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE

RELEASE IS VALID FOR: **ONE YEAR** **TERMINATION OF TREATMENT**

REVOKED (Please circle one)