FamilyFirst Psychological Services • 8381 Old Courthouse Road, Suite 330, Vienna, VA 22182 • T 703.938.9090 • F 703.938.9091 • familyfirstva.com

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

I authorize _____ (Clinician Name) at FamilyFirst Psychological Services, PC to exchange information regarding the above named individual as described below.

The type of information to be exchanged is as follows:

_____

This information may be exchanged with the following individual or organization:

Name: _____

Address/Phone: _____

_____

I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire at the end of treatment, unless an expiration date, event or condition is specified as follows: _____

I also understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and therefore: 1) FamilyFirst and your clinician have no responsibility or liability as a result of the re-disclosure, and 2) your information is no longer protected by state or Federal privacy law.

_____

Name of Parent/Guardian (if client is under 18)

_____ _____

Signature of Client (if over 18) or Signature of Parent/Guardian Date