VIRGINIA COMMONWEALTH UNIVERSITY

Center for Psychological Services and Development
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CONSENT FOR RELEASE OF INFORMATION

Client Name: _____ DOB: _____

Responsible Party (if other than client): _____

Relationship to Client: _____

Therapist's Name: _____

I hereby authorize the release of information:

To / From: VCU Center for Psychological Services and Development
612 N. Lombardy St
Richmond, VA 23284

To / From: Name: _____

Address: _____

Phone: _____ Fax: _____

Information to Disclose:

☐ Complete Medical/Mental Health Records ☐ Documentation of Attendance
☐ Treatment Plans / Progress Notes ☐ Intake / Termination Summaries
☐ Assessment Report ☐ Other: _____

Purpose for This Disclosure:

☐ Coordination of Care ☐ Insurance ☐ Other: _____

Method of Disclosure: ☐ Written ☐ Verbal

Authorization Expires:

☐ When no longer receiving services at CPSD ☐ One year from date signed ☐ Other (specify): _____

As the person signing this authorization, I understand that:

- I am authorizing the Center for Psychological Services and Development (CPSD) to disclose my confidential health records. A copy of this authorization and documentation of release of my health information shall be maintained.
- The CPSD will not condition treatment on whether or not I sign this authorization.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken upon it. My revocation will not be effective until delivered in writing to the CPSD. A copy of my revocation shall be maintained.
- I understand that health information disclosed pursuant to this authorization might be re-disclosed by the recipient and, in such case, may no longer be protected by federal privacy regulations.
- A photocopy/fax of this authorization will be treated in the same way as an original.

My signature indicates that I have read and that I understand this form.

_____ _____
Client Signature Date

_____ _____
Responsible Party (if other than client) Date