WellSpring Child and Family Psychology, PC

615 Jefferson Davis Highway, Suite 101
Fredericksburg, VA 22401
Phone: (540) 693-0096

Consent for Release of Information Form

Information to be released/exchanged (initial by *all* types of information you would like to authorize to be exchanged):

___ Psychotherapy Notes
___ Psychological Testing/Assessment Results
___ School Records
___ Information Related to Substance Abuse/Treatment
___ Behavioral Observations
___ Verbal Consultation
___ Medical Records
___ Other: _____

Reason for Disclosure: ___ Continuity of Treatment ___ Other: _____

I consent to allow the exchange of information between the following individuals/entities:

Provider(s)_____
WellSpring Child and Family Psychology, PC
615 Jefferson Davis Hwy, Suite 101
Fredericksburg, VA 22401
Phone: (540) 693-0096

AND

_____
Name of Institution Name of Individual

_____
Address

_____
Phone Fax

Dates of Disclosure: This consent will be valid until: _____ or until the following event: _____.

Authorization and Signature: I hereby authorize the exchange of the above Protected Health Information as specified in this consent form. I understand that the disclosure of this information is voluntary and that my consent may be revoked in writing at any time. I understand that protected information may be re-disclosed by the recipient unless the recipient is subject to laws that limit the re-disclosure of protected health information.

_____ _____
Client Name Client Date of Birth

_____ _____
Signature of Client Date of Consent (Effective Date)

_____ _____
Signature of Authorized Representative Relationship to Client