

# WellSpring Child and Family Psychology, PC

510 Princess Anne St, Suite 101  
Fredericksburg, VA 22401  
Phone: (540) 693-0096  
Fax: (540) 750-4057

## 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  Behavioral Observations  
 Psychological Testing/Assessment Results  Verbal Consultation  
 School Records  Medical Records  
 Information Related to Substance Abuse/Treatment  
 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  
510 Princess Anne St, Suite 101  
Fredericksburg, VA 22401  
Phone: (540) 693-0096  
Fax: (540) 750-4057

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