Sessions RVA, LLC

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I hereby authorize the disclosure of pertinent mental health/substance abuse information to the following agency/individual for the purpose of coordinating care. I understand that I may revoke this authorization at any time by notifying Gwendolyn L. Bohn, MT, LCSW, CYT, at Sessions RVA, LLC, in writing. Should consent be revoked, I understand that doing so will not have any effect on information disclosed prior to the revocation.

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Name of Parent/Legal Guardian (if patient is a minor: _____

_____ I give my permission for Gwendolyn L. Bohn, LCSW, at Sessions RVA, LLC, to *obtain* confidential healthcare, educational, and/or personal information from the following agency or individual:

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

_____ I give my permission for Gwendolyn L. Bohn, LCSW, at Sessions RVA, LLC, to *release* confidential healthcare information to the agency or individual listed above.

I request that information to be shared be limited to the following (optional):

_____

_____

This authorization expires one year from the date of the signature unless otherwise specified. I understand that I have the right to revoke this authorization at any time prior to its expiration. Expiration if sooner than 1 year: _____

_____ _____

Signature of Patient or Parent/Legal Guardian Date