

**Beach Counseling Center LLC**  
Authorization to Receive Confidential Information

Name \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

The above patient request medical records to be released from:

Facility/Name \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Records to be sent to: Beach Counseling Center, Therapist: \_\_\_\_\_  
1064 Laskin Road, Suite 14C or 1009 Frederick Road  
Virginia Beach, VA 23451 Catonsville, MD 21228

Specific type of information to be disclosed:

- |   |  |
|---|--|
| <input type="checkbox"/> Initial Evaluation               | <input type="checkbox"/> Summary of Psychotherapy visits |
| <input type="checkbox"/> Psychotherapy Records            | <input type="checkbox"/> Medications Record              |
| <input type="checkbox"/> Psychological Evaluation Results | <input type="checkbox"/> Other _____                     |

Date(s) of treatment or contact: \_\_\_\_\_

The purpose or need for such disclosure:

- |  |  |
|--|--|
| <input type="checkbox"/> Continuity of care  | <input type="checkbox"/> Transfer of Care  |
| <input type="checkbox"/> Court related issue | <input type="checkbox"/> Employment Issues |
| <input type="checkbox"/> School Records      | <input type="checkbox"/> Other _____       |

Method of transmission:  Written information  Telephone  Fax

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that any information released prior to my revoking this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke the authorization prior to such time, this authorization shall expire 365 days from today's date.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Legal Guardian or Parent \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA Privacy Rule.) This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure, dissemination or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed below) to arrange the return or destruction of the information and all copies.

1064 Laskin Road Suite 14C, Virginia Beach, VA 23451 (757) 233-1500 Fax (757) 222-3833