# 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:

- ___ Initial Evaluation
- ___ Psychotherapy Records
- ___ Psychological Evaluation Results
- ___ Summary of Psychotherapy visits
- ___ Medications Record
- ___ Other _____

Date(s) of treatment or contact: _____

The purpose or need for such disclosure:

- ___Continuity of care
- ___Court related issue
- ___School Records
- ___Transfer of Care
- ___Employment Issues
- ___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_____