Riley Counseling and Consulting, PLC
Authorization for Release of Information

Patient Name (Last, First, MI):	Date of Birth:
Social Security No:	Covering Records for Period of (Dates): to

I hereby authorize _____ to ☐ release/ ☐ receive my confidential medical record information including dates, history of illness, diagnostic and therapeutic treatment. The medical records to be released may contain medical information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment. In addition, I authorize disclosure of medical records received from other providers.

Information to be released:

☐ Complete Health Record
☐ History and Physical Examination
☐ Admission Summary Report
☐ Discharge Summary Report
☐ Laboratory Reports
☐ Drug Treatment and Counseling Reports
☐ Psychiatric Summary Reports
☐ Other: _____

Information to be released to:

☐ Ebonie Riley Walker, LCSW • 3419 Va Beach Blvd #366 Virginia Beach, VA 23452
Phone: 757-285-4413 • Fax: 757-401-6962

☐ Other: _____

Purpose of Disclosure: ☐ Patient is under clinician's care and needs follow up treatment

☐ Other:_____

This authorization shall remain in full force and effect until withdrawn by me and I understand that this consent can be revoked in writing at any time. This revocation will not cover disclosures made previously in reliance on the consent. This authorization will expire 1 year from the date noted below.

The practice, it's employees, officers and other staff are released from legal responsibility or liability for release of information in accordance with this consent.

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment for this named patient.

Patient Signature:	Date:	Witness Signature:	Date:

Revised 8/2/2019