Dr. Stephen R. Band, LPC, LMFT

Behavioral Intelligence Specialists, LLC

8425 Dorsey Circle, #102

Manassas, Virginia 20110

Tele. 540-846-5429

behavioralintelligencespecialist@starpower.net

www.drstephenrband.com

Consent to Release Information

Client name______________________________ Date_____________________________________

I, ___________________________, consent to release information regarding my counseling, therapy and /or testing with ____

To the following individual (s): ____

____

____

Information to be released or exchanged includes (check all that apply):

___________Discharge and summary ________________ Progress Notes

___________Behavioral Health Treatment Records __________Medication Records

___________Case Summary _____________________School records

Other (Specify) ____

This authorization shall expire: ____

I understand that I may withdraw my consent at any time. I understand that my health and behavioral health records are protected from being shared under Federal and state laws. I may change this permission. This permission is valid until changed or sixty (60) days after I have completed treatment, whichever is sooner. Once I revoke this permission, no information can be released except as allowed by law. A file copy is as good as the original.

This authorization was explained to me and I signed it of my own free will:

Signature of Client/Parent_____________________ Date: __________________________

Signature of Witness__________________________ Date: _________________________