Adolescent and Family Growth Center, Inc
8000 Forbes Place
Springfield, VA 22151
(703) 425-9200

RELEASE OF INFORMATION

I/We understand that different agencies provide different services, but under the Freedom of Information Act, without my/our permission, any information regarding my/our case cannot be exchanged with another agency.

Client Name: _____ DOB: _____

I authorize: _____

____ to exchange information with

____ to release information to

____ to receive from

_____
Name of Person, Organization, or Institution

_____
Address and Telephone Number

For the Purpose of Diagnostic assessment and/or treatment planning

The following confidential information may be exchanged in written form, oral information, and/or computerized data:

____ Medical Records ____ Social Services Record _____ Assessment Information

____ Educational Records ____ Residential Treatment _____ Mental Health Information

____ Psychological Exams ____ Other Information

If other, please specify the information to be released:

_____

_____

This release of information is valid for one year.

I understand that I can withdraw this permission at any time. I have the right to know what information has been shared, why, when, and with whom. I want the above noted agencies to accept a copy of this form as consent to share information with Adolescent & Family Growth Center, Inc.

_____ _____
Signature Date

_____ _____
Witness Signature Date