Hanover Counseling Associates, PLLC

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

CLIENT'S NAME_____ **MR#** _____

ADDRESS _____

CLIENT'S DATE OF BIRTH _____

FROM:	**TO:** Name, Address, and Phone # of Person/Organization:
Hanover Counseling Associates, PLLC 8249 Crown Colony Pkwy Suite 200 Mechanicsville, VA 23116 804-789-1224 ***Therapist:*** _____	

EXTENT AND NATURE OF INFORMATION TO BE DISCLOSED:

Permission to discuss case information or any other pertinent records, patient files, psychological reports, assessments, treatment plan goals, and progress notes with authorized personnel.

PURPOSE OR NEED FOR INFORMATION:

_____

_____

CONSENT TO RELEASE INFORMATION

I hereby authorize the release of information requested above from my record. I understand that the information to be released from my record is confidential and protected from disclosure without my signing this written authorization. I also understand that I have the right to cancel my permission to release information at any time before it is released.

Effective Date:_____ **Expiration Date**:_____

_____ **Date Signed**:_____

Signature of Client

_____ **Date Signed**:_____

Signature of Witness