Capitol Hill Consortium for Counseling & Consultation LLC
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Patient Information Release Authorization
Communication and/or Records

Patient Name	Date of Birth	Social Security Number

I hereby authorize Capitol Hill Consortium for Counseling & Consultation LLC to release my records and/or to communicate my treatment plan(s), examination(s), and or testing with the person or entity named below.

Physician/Organization/Individual information is authorized to be released to:

Organization Name	
Contact Person	
Street	
City	
State / Zip Code	
Telephone Number	
Fax Number	

The information should include the diagnosis and records of any treatment, examination or testing rendered to me during the period of _____ to _____.

The patient (parent/guardian, if minor child) in writing may end this authorization at any time.

Printed Name of Patient (Parent or Guardian if minor child)	Signature	Date
Witness Name	Witness Signature	Date

NOTE TO THE PARTY RECEIVING INFORMATION; This information has been disclosed to you from records whose confidentiality is protected by federal law which prohibits you from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. (This form meets the requirements of Federal Regulations 42 CFR).