Capitol Hill Consortium for Counseling & Consultation LLC
650 Pennsylvania Avenue SE, Suite 440, Washington, DC 20003
P | 202.544.5440 F | 202.544.3004

Patient Information Release Authorization-Under 18

Communication and/or Records

Patient Name	Date of Birth	Social Security Number

I hereby authorize the following individuals to have access to my child's information and medical records, including any parent or family members that are not present at the initial session that you would like to have access.

First and Last Name	Phone number/email

The information may include the diagnosis and records of any treatment or examination rendered to my child during the period of _____ to _____.

The parent/guardian may end this authorization at any time in writing.

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

Clinician Name | Clinician Signature | Date