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
Communication and/or Records

Patient Name	Date of Birth	Social Security Number

I hereby authorize the following Physician/Organization or Facility to release my records and or to communicate with_____ at CCCC.
(Name of Therapist)

Physician/Organization or Facility to receive this release

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

The information should include the diagnosis and records of any treatment or examination 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

Mail records to: Capitol Hill Consortium for Counseling & Consultation
650 Pennsylvania Avenue, SE
Suite 240
Washington, DC 20003
Attn: Medical Records

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).