Christine Komiske Dwyer, LCSW

4581 Lifestyle Lane
Midlothian, Virginia 23112
Phone: (804) 608-9430 Fax: (804) 510-0555

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

to release/exchange healthcare information of the patient named above to/with:

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Midlothian, Virginia 23112
Phone: (804) 608-9430

[ ] I do not place any restrictions on information provided, leaving this to the discretion of staff.

[ ] This request and authorization is limited to:

☐ Information required to coordinate care
☐ Client's presence in treatment/dates of treatment
☐ Treatment Plan
☐ Psychological/Intake evaluation(s)
☐ Educational Information
☐ Current Medications
☐ Discharge Summary
☐ Current treatment plan
☐ Other: _____
☐ Healthcare information relating to the following treatment, condition, or dates: _____

By signing this, I acknowledge that I am giving my permission to the above named person/staff to disclose and use protected health information. I further acknowledge that:

- I have the right to refuse to sign this authorization with no penalties or impact on treatment.
- This release is valid for one year from the date of signing.
- I have the right to revoke this authorization in writing at any time.

Patient/Guardian Signature: _____ Date Signed: _____

Minor Signature (age 13 and over): _____ Date Signed: _____