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RELEASE OF INFORMATION

PATIENT'S NAME: _____ DOB: _____

The patient listed above hereby authorizes

Ann Boyer Holmes, MSW

to RECEIVE/DISCLOSE individually identifiable health information of the patient
(as described below) TO/FROM

Name of individual/organization

Address of individual/organization

Fax and phone number of individual/organization

Specific dates needed: _____.

These disclosures are for the purposes of (i.e., continued care, personal, etc.)

_____.

This information is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychology), or drug and/or alcohol abuse. I understand that I may revoke this authorization at any time. (Initial)

I understand that unless earlier revoked, this authorization will expire on ____/____/____
or on the happening of _____ (if no date or event is
specified, authorization will expire six (6) months after that date of signature below).

Please note that Fairfax Mental Health is not a partnership. Each professional in this office is an independent provider and shares no responsibility or liability for the advice given to the undersigned unless requested to render a service.

Client

Date