950 N Washington St
Suite 322
Alexandria, VA 22314
Phone: 703-408-3512
www.healthyminds-therapy.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I hereby authorize the communication of clinical information between Alycia Burant, LPC at Healthy Minds Therapy, PLLC and the following individuals: *(Please initial, date, and mark all that apply)*

○ _____ (Initial and date)
Primary Care Physician _____
Address _____
Phone/Email (P) _____ **(E)** _____

○ _____ (Initial and date)
Psychiatrist _____
Address _____
Phone/Email (P) _____ **(E)** _____

○ _____ (Initial and date)
School/Teacher_____
Address _____
Phone/Email (P) _____ **(E)** _____

○ _____ (Initial and date)
Other _____
Address _____
Phone/Email (P) _____ **(E)** _____

Communication may include direct verbal communication, clinical documentation including inpatient and outpatient treatment notes, discharge summaries, testing and laboratory results, and similar clinically relevant materials. I understand that I may withdraw this consent at any time by submitting a request in writing. Please note that once the requested information is disclosed pursuant to this Authorization, Healthy Minds Therapy will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

Signature of Client Date Signed

Print Client Name Date of Birth

** This authorization for release of information is good for one year after date signed, until client revokes authorization, or until client is discharged from treatment (whichever precedes).