Beyond Counseling, Inc.
11250 Roger Bacon Dr. Atrium #5
Reston, VA 20190
703-261-9201 (phone)
703-995-4642 (fax)

General Release of Information

Client Name _________________________________ Date of Birth ___________________

I hereby give my written permission for Beyond Counseling, Inc. to exchange the following verbal or written information as indicated with:
____ (Name or Entity). The contact information of aforementioned person is: ____________________________ (phone), _________________(fax), and/or ____ (email).

Extent or nature of use/disclosure is limited to: (Check all that apply)

☐ Discharge Notes	☐History and Physical	☐Psychiatric Evaluation	☐ Progress Notes
☐ Medical Records	☐ Treatment Plan	☐ Lab Work	☐ Consultations
☐ School Records	☐Psychological Evals	☐ Case Coordination	☐ Medication Management
☐ Diagnostic Information	☐ Treatment Recommendations	☐Other (Please indicate)	

Date and/or condition when release will expire: ____________________
(If not specified, the release will expire one year from the date signed or 30 days from discharge, if this occurs before one year.)

**As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose, and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations, or eligibility are not conditional upon giving authorization. The original, or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. The authorization is automatically revoked upon termination of service.*

The person who receives the records to which this authorization pertains may not redisclose them to anyone else without my separate written authorization unless such recipient is a provider who makes a

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disclosure permitted by law. A general authorization for the release of medical or other information is not sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or federal law protect the disclosed confidential information. Federal regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Client/Guardian ____________________________________ Date _____________

Signature of Staff Witnessing ____________________________________ Date _____________

☐I decline to release my medical information.