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

Release of Medical Information

Date of Release_____/_____/_____

Dear Dr._____(Primary Care Physician),
(First Name and Last Name)

We are currently working with your patient, _____, in outpatient mental health counseling. Many insurance carriers require that health information on clients must be obtained. In order to fulfill this requirement, we must request that you either mail or fax the client's latest physical health information.

Our mailing address is: Beyond Counseling, Inc.
11250 Roger Bacon Dr. Atrium #5
Reston, VA 20190

Our fax number is: (703) 995-4642

Client Information:

Address: _____
City, State, Zip Code _____
Date of Birth _____ Last 4 digits of Social Security # _____

Thank you for your prompt attention and your cooperation in this matter. Below you will find the signatures of the client/ guardian indicating agreement with this release.

Signature of Client/Guardian _____ Date _____

Signature of Staff Witnessing _____ Date _____

Date Sent to PCP: _____

☐I decline to release my medical information.