Center for Integrated Recovery, LLC
1110 Rose Hill Drive, Suite 201
Charlottesville, VA 22903
(434) 414-7203

Authorization for Release of Confidential Information

Client Name: _____ Date of Birth: _____

I hereby authorize: **Center for Integrated Recovery, LLC**

To release: _____ To receive: _____ confidential information (via: mail, email, telephone and/or FAX) related to mental health, addiction, and/or psychiatric/psychological treatment, including records of testing, medication, diagnosis, assessment, and insurance records as applicable, **with the following person or organization:**

_____

The extent or nature of information to be disclosed is:

- Psychiatric records: _____
- Personal assessment: _____
- Progress notes: _____
- Billing: _____
- Other (specify): _____

The purpose of this disclosure is:

Continued care: _____ Processing of insurance claim: _____ Billing: _____ Other: _____

Comply with this release automatically: _____ Comply with this release on request: _____

This authorization expires on: _____ unless revoked by me in writing prior to that date. If no date is specified by me, the authorization will expire in one year. I understand that I may revoke my consent to allow release of this information, except to the extent that action has been taken on the information released prior to the revocation of my consent.

_____ _____

Client Signature Date

_____ _____

Witness Date