Liberty University Health Services
1971 Liberty University Blvd, Suite 1895
Lynchburg, VA 24502
Telephone: (434) 200 – 6370
Fax: (434) 455 – 0966

Authorization for Release and/or Exchange of Confidential Information

Patient's Name: _____ Date of Birth: _____

By signing this consent, I understand that I am giving my permission to both parties to exchange all confidential health records, including mental health records and/or appropriate information acquired in the course of my evaluation and treatment. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent shall be included with my original records. The person who receives the record to which this consent pertains may not disclose them to anyone else without my separate written consent un less such recipient is a provider who makes a disclosure permitted by law. This authorization is between the parties named below:

Release to:
Name: _____

Address: _____
_____
_____

Obtain from:
Name: _____

Address: _____
_____
_____

Information requested includes (circle choices)

Medical Information	Social History Information	Legal Information
Psychological Testing	Education Records	Other _____

In consideration of this consent I hereby release the above parties from any legal liability for the release of this information. This document serves as a release of information for medical and mental health records to include verbal communication between Liberty University Health Services and the individual or agency above. This authorization included information placed in my record both before and after the date of my signature. I understand the information released may include information related to substance abuse and/or HIV/AID status unless otherwise indicated.

Date: _____

Signature: _____
(Patient, parent, or guardian)

Date of Expiration: _____

_____
(Relationship to patient)

_____
(Signature of Witness)