BiofeedbackWORKS
(703) 689-0449
in Virginia PLLC

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Authorization to Release Protected Health Information

Patient Name:_________________________________ **Date of Birth:** __________________

I hereby give BiofeedbackWorks in Virginia authorization to:

☐ Release information to: ☐ Obtain information from: ☐ Discuss Information with:

Name: ____

Address: ____

City, State, Zip: ____

Phone: _____________________________ **Fax:** __________________________

Purpose of Disclosure:

☐ Coordination of Care
☐ Other:______________________________

Type of Information to be released: ____

This authorization covers

☐ from ________________ to _________________.
☐ all records

This authorization

☐ expires one year after date of signature below.
☐ expires (date): _____________________________
☐ does not expire.

I understand that I may revoke this authorization, in writing, at any time.

____ _______________________

Signature: CLIENT Or Person Authorized To Give Authorization) *Date*