BiofeedbackWORKS
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name: _____ **Date of Birth:** _____

I AUTHORIZE BIOFEEDBACK*WORKS* IN VIRGINIA TO:

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

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

Email:_____

- **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 *Date*

- Signed by: ☐ *CLIENT* ☐ *GUARDIAN* ☐ *OTHER AUTHORIZED INDIVIDUAL*
  Nature of authorization: _____

_____ _____
Signature of Witness *Date*