Duffy Counseling Center
1487 Chain Bridge Road
Suite 300
McLean, VA 22101
703.255.1091
www.DuffyCounseling.com

Release of Information

Client Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

I, the undersigned, have read the above and authorize **Duffy Counseling Center** of the disclosing to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Authorize the following individual/organization/provider:

Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

This release remains in effect from _____ to exactly 90 days after date of discharge.
(Date or Event)

- I understand that service providers using or disclosing information based on this authorization to share the minimum necessary amount of the specified information to accomplish the purpose of exchange of information.
- The provision of treatment, payment, enrollment, or eligibility for benefits does not depend on whether I sign this authorization.
- I may revoke (or cancel) this authorization at any time by submitting written request to staff of the Duffy Counseling Center.
- The information to be released has been fully explained to me and this authorization is given of my own free will.
- I am entitled to a copy of this signed authorization.

Individual's Signature: _____ **Date:** _____
Other Signature: _____ **Date:** _____
Therapist's Signature: _____ **Date:** _____