Mind Health Center, LLC
5700 West Grace St., Suite 105-A
Richmond, VA 23226
804-442-3116
www.mindhealthcenter.net

# AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, hereby authorize The Mind Health Center, LLC, to discuss information relevant to my case/coordination of care with the below named person(s). I understand that this release of information is valid from the date of this authorization to the time I terminate treatment with The Mind Health Center, LLC. Termination is deemed to occur when I discontinue contact with The Mind Health Center, LLC, either formally or informally, no longer wish to seek treatment, or when terminated by a licensed clinician employed by The Mind Health Center, LLC.

Name: _____

Address:_____
_____

Telephone: _____Fax:
_____

Information to be Released or Discussed:

- ☐ Intake/Treatment Plan
- ☐ Treatment Progress
- ☐ Diagnosis
- ☐ Discharge Summary
- ☐ Verbal Consultation
- ☐ Billing & Payment Information
- ☐ Other (specify)_____

_____ _____

Client's Signature Date

_____ _____

Guardian's Signature if Client is a minor Date