

Full Circle Neuropsychiatric Wellness Center

11490 Commerce Park Drive, Suite 420 Reston, VA 20191

Tel: 703-481-9111 Fax: 703-707-8657

Authorization to Release Protected Medical Information

Patient's Last Name:	First:	Date of Birth:	
Street Address:		Home Phone:	
City:	State:	Zip Code:	Cell Phone:

I hereby give Full Circle Neuropsychiatric Wellness Center authorization to (specify):

Discuss Information with*:

Company/Provider/Person Name:	
Address:	
Phone:	Fax:

Covering the period(s) of treatment from _____ to _____ / All

Information to be Discussed:

- Records – Date(s) specified above
- Lab Work – Date(s) specified above

For the purposes of:

- Coordination of care with another provider
- Moving/Transferring Care
- Insurance/Disability/Legal

Other (specify) _____

* I understand that there may be a fee associated with this discussion. The fee (s) associated with this discussion authorization request will be the sole financial responsibility of the patient and/or their authorized representative.

I understand that this authorization will expire in **ONE YEAR** unless otherwise indicated here:

Until records are obtained 6 months Never Other: _____. I understand I may revoke or edit this authorization at any time by providing written notification to FCNWC; however this will not affect actions taken prior to the receipt of my alteration. In the case of a minor, this authorization will expire once the patient turns 18 years of age.

Printed name of Patient or Authorized Representative

*If you are not the Patient, indicate relationship to Patient: Parent or Legal Guardian Power of Attorney

Signature of Patient or Authorized Representative

Date