PATIENT CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION

Date: ________________________

I hereby authorize and request THE VIRGINIA INSTITUTE OF PASTORAL CARE, INC. to furnish:

Name: ____

Address: ____

City, State, Zip: ____

with information as may be desired from my medical and/or other records. Such information may include: personal history, the results of psychological testing or other assessments, and discharge summaries.

Signature: ____

Printed Name: ____

Address: ____

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This information will be used to assist in my counseling received at VIPCare. This authorization will expire on __________________________, 20______.

Witness: ____