Quarternote Counseling LLC
9255 Center Street, Suite 210
Manassas, Va., 20110
703 675 5361

RELEASE OF INFORMATION PRIMARY CARE PHYSICIAN

(Because Quarternote Counseling accepts Medicaid, we are required to document that we requested a release for the Primary Care Physician for every single client, regardless of whether they have Medicaid or not. You are welcome to provide or not provide this information. If you decline to provide this information, please check the appropriate section and sign.)

Client Name: ____ DOB: ___________________________

____ I hereby DECLINE to authorize Quarternote Counseling, LLC to coordinate services with my Primary Care Physician

____ I hereby give my written permission for Quarternote Counseling LLC to exchange verbal and written information about the following matters:

Diagnosis, Progress in Therapy, Interaction of Medical and Mental Health Issues, Medication Compliance and Impact on Symptoms if client is prescribed Mental Health medication, Substance Use

With the following organization/individual: (Name, Address and Phone Number of Primary Care Physician)

Purpose of information exchange is: Coordination of Services

I understand that I may refuse to authorize release of my confidential information to others if I so choose. I understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below. I also understand that this information may be subject to re-disclosure by the party receiving the information and my no longer be protected.

I allow the listed agency to accept a copy of my form as a valid consent to release information. This consent includes information which is placed in the record after the date this consent was signed, unless noted otherwise.

This consent expires on the following date, ____________________________________, **OR** when my case and file with Quarternote Counseling has been closed, whichever occurs first.

(For minor clients only) Name of client's parent/legal guardian: ____

(For minor clients only) Relationship of parent/legal guardian to client: ____

Signature of Client/Parent/Legal Guardian: ____

Date: ______________________________