Resource Guidance Services, Inc
5352 Twin Hickory Rd
Glen Allen, VA 23059
Phone (804) 592-2793 Fax (804) 592-2794

Authorization to Release, Exchange, or Obtain Information

I, (client's full name; please print) _____, authorize Resource Guidance Services to:
___ release, ___ exchange, ___ obtain
the following information: ___summary of previous counseling
___hospitalization records
___psychiatric evaluation
___other (please specify:_____

_____)
This information will be ___released to, ___exchanged with, ___obtained from:
(Name and address of person and/or agency)

_____

_____

_____

(Telephone)_____ (Fax)_____

My consent is given for 12 months from the signature date of this document or through: _____.

I may revoke this authorization at any time by submitting a written statement directing my provider or Resource Guidance Services, Inc to cancel this authorization.

I understand that I have the following rights:

1. I am eligible for services whether or not I sign this form.

2. My signature on this form authorizes either my provider or Resource Guidance Services, Inc to release, exchange or obtain information to/with/from only the person or agency named on the form.

3. I have the right to have my provider explain what type of information will be released, exchanged, or obtained and the right to inspect the protected health information to be used or disclosed.

4. I have the right to revoke this authorization at any time by submitting a written statement directing Resource Guidance Services, Inc not to release, exchange, or obtain designated information.

_____ (date)_____
(signature of client)

(date of birth) ___/___ / ___

(Provider's name; please print) _____

(signature of provider) _____