

BLUE RIDGE PSYCHOLOGICAL CENTER
7520 GARDNER PARK DRIVE
GAINESVILLE, VA 20155
571-248-2358

RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I give permission to _____ to release/exchange information with:

Name: _____ Phone: _____

Information to be released/exchanged:

All mental health/substance abuse information

Other: _____

Client or Parent/Guardian Signature

Date