**Fly Family Therapy and Neurotherapy**

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FLY FAMILY THERAPY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name: |  | Date of Birth: |  |
| Parent Name (if under 18): |  | Social Security #: |  |
| I request and authorize |  | to |
| release information regarding medical, psychological, and mental health treatment information of the patient named above to: |
|  | Name: |  |
|  | Address: |  |
|  | City: |  | State: |  | Zip Code: |  |
| This request and authorization applies to: |
| 🞎 Healthcare information relating to the following treatment, condition, or dates: |  |
|  |  |
| 🞎 All healthcare information |
| 🞎 Other: |  |
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|  |  |
| Patient (or Parent, if under 18) Signature: |  | Date Signed: |  |
|  |
| THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER IT IS SIGNED. |