VIRGINIA CENTER FOR NEUROFEEDBACK
ATTACHMENT & TRAUMA

Authorization to Release Information

Client Name: ___________________________________ Date of Birth: ________________

I authorize Jessica M. Eure, LPC, BCN to: [ ] Release Information [ ] Receive Information

Agency: ____

Attention to: ____

Address: ____

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Phone: ________________________ Fax: _____________________________

The information to be released and/or received is:

[ ] Intake Information
[ ] Progress Notes
[ ] Neurofeedback Treatment Summary
[ ] QEEG & BSI Report
[ ] Other: ________________________

The purpose of releasing this information is:

[ ] To coordinate services
[ ] To inform referral source
[ ] To comply with court/subpoena
[ ] Other: _________________________

The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by my written consent, or as otherwise permitted by 42 CFR Part 2.

Client Signature (or Guardian): ______________________________ Date: _______________

Jessica M. Eure: ____ Date: ________________

Effective from signature date until notified by client or until treatment with this office has ceased.

Jessica M. Eure, LPC, BCN
jessica@virginianeurofeedback.com
420 3rd Street NE, Charlottesville, VA 22902
Office:(434)878-3146 Fax:(434)326-4583