

**C2 Your Health, PC**  
8720 Forest Hill Avenue  
North Chesterfield, VA 23235  
P (804) 325-1669, F (804) 325-1670

**Authorization to Release/Request Medical Information**

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian Name (if patient is a minor): \_\_\_\_\_

I hereby give: (check provider)

- Erin Butterworth, LCSW
- Rebecca Jacobson, LPC, ATR, LMT
- Christine Lamps, LCSW
- Dr. Christopher Lamps, MD, FAACAP
- Lynda Leslie, LCSW
- Dr. Sarah McElroy, PhD, LCP
- Joanne Moore Paek, LPC
- Elizabeth Shurte, LPC

Authorization to:

Release Information:

Request Information:

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Covering the periods of treatment from: \_\_\_\_\_ to \_\_\_\_\_ OR  ALL DATES

Information Requested:

Records

Lab Work

Coordination of care w/ another provider (treatment plan, disability, legal)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby understand there is a 7-10 business day processing period. I have been informed that this release remains in force as for the duration of treatment at C2 Your Health, PC unless otherwise noted in writing. A photocopy of this form is considered as valid as the original and is protected by Federal law and HIPAA regulations.