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
- Carrie Kerr, 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, MS
- Elizabeth Shurte, MA

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.