COMMONWEALTH of VIRGINIA

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AUTHORIZATION FOR DISCLOSURE OF INFORMATION

By my signature below, I authorize any practice supervisor approved by the Board of Counseling ("Board") to disclose information and communicate with the Board regarding the supervision of my practice in the Commonwealth of Virginia. I understand that disclosure may include, but is not limited to, identify of my clients, their medical history, diagnosis, prognosis, dates of treatment, treatment, test results, summary reports, and consent forms, and this disclosure is without limitation as to the period of treatment, diagnosis, therapeutic information, or history of type of illness, including alcohol or drug abuse.

I understand this disclosure may take the form of ongoing verbal or written communication between the practice supervisor and the Board, or its agent during the valid dates of this authorization, and may include the disclosure of information or reports in the possession of the Board to the practice supervisor.

I understand the information obtained by use of this authorization will be used by the Board in their efforts to determine my compliance with the terms and conditions in my Board Order and my ability to practice with reasonable skill and safety, and will be used by the practice supervisor to form an opinion and make a recommendation to the Board regarding my ability to practice in Virginia.

Any information obtained will not be released by the Board or the practice supervisor to any person or organization except as necessary during an administrative proceeding held to determine my fitness to practice, my compliance with terms, or as may be otherwise lawfully allowed or required, or as I may further authorize. In addition, I understand that any information obtained may be released to any individual who is designated to supervise or monitor my practice as the Board's agent pursuant to a Board Order.

I know that I may request to receive a copy of this authorization. I agree this authorization will terminate upon my formal written release, by the Virginia Board of Counseling, from the terms of my Order, or five (5) years from the date the authorization is signed.

My Printed Name	***My Signature***	***Date Signed***
Printed Name of Witness	Signature of Witness	Date Signed
Street Address of Witness	City / State of Witness	Zip of Witness

Return signed original to Compliance Case Manager, Board of Counseling, 9960 Mayland Dr., Suite 300, Henrico, Virginia 23233