Aligned Clinical & Educational Services (ACES), PLC
MAILING ADDRESS: P.O. Box 28, Crozet, VA 22932
OFFICE ADDRESS: 325 Four Leaf Lane, Suite 12, Charlottesville, VA 22903
PHONE: (434) 466-1588 VP: (434) 326-1496 FAX: (434) 823-1174

RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION FORM

Name of Client:	
Date of Birth:	
Printed Name of Legal Guardian:	

As the adult client or legal guardian for the above person, I grant permission for Aligned Clinical & Educational Services PLC to: (Check all that apply)

_____**RECEIVE/** _____**SHARE** information for the purpose of clinical, medical and educational services:

Name:	
Title:	
Address:	
City, State, Zip Code:	
Phone:	
Fax:	
Email:	

As the person signing this authorization, I understand that I am giving permission to Aligned Clinical & Educational Services, PLC for disclosure of confidential health records. I understand that receiving clinical, medical and/or educational services from Aligned Clinical & Educational Services, PLC is not dependent upon my willingness to sign this authorization, unless upon review, critical health care information is needed, that without, would result in invalid services. I understand I have a right to revoke this authorization at any time, but the revocation is not effective until it is provided in writing to Aligned Clinical & Educational Services. I understand that when Aligned Clinical & Educational Services, PLC discloses information to a third party with your consent, it is possible the third party will not protect the confidential information in the same way that a health care provider does by law. This consent will remain in effect for one calendar year unless otherwise noted.

Signature of Client or Legal Representative: _____

Address:_____Date:_____

If signed by a Legal Representative, please indicate your relationship to the client.

___Parent ___Legal Guardian ___Other _____