



Aligned Clinical & Educational Services (ACES), PLC
MAILING ADDRESS: P.O. Box 28, Crozet, VA 22932
CROZET: 325 Four Leaf Lane, Suite 12, Charlottesville, VA 22903
MIDLOTHIAN: 4920 East Millridge Parkway, Ste 206, Midlothian, VA 23112
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:

RECEIVE / SHARE

information for the purpose of clinical, medical, and educational services with the following entity:

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 healthcare 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 healthcare 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 : _____