Kirby Creative Clinical Solutions, LLC
3929 Old Lee Hwy; Unit 92-D
Fairfax, VA 22030
703-409-2571
Tax ID # 27-2924949

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ____, authorize Heather H. Kirby, LCSW

and ____ to exchange confidential

information for the purpose of coordinating educational services and/or mental health

treatment for (client) ____.

The following are email and/or phone numbers for this collaboration.

Phone: ____

Email: ____

I understand that I can revoke this authorization at any time by providing written notification.

____ ___________________

Signature of Client Date

____ ___________________

Signature of Parent or Guardian Date

____ ___________________

Signature of Therapist Date