301-949-2098

CONSENT FOR RELEASE OF PROFESSIONAL INFORMATION

Name: _____

I (we) hereby authorize and request:

Provider: _____

to release confidential information to and also from the following professional contacts:
_____
_____
_____

I understand that the information will be used for professional purposes only and will not be released to anyone else without written permission. The specific information requested is as follows:

_____ Assessment/Testing _____ Psychiatric Treatment

_____ Psychological Treatment _____ Ongoing Status

_____ Academic Reports _____ Discharge Summary

_____ Admission Summary _____ Other _____

I understand that I may revoke this consent at any time by informing, in writing, the above named individuals. This consent will automatically terminate one year from the date of my signature below.

_____ _____
Provider's Signature Date Client's Signature Date

_____ _____
Parent's Signature Date Guardian's Signature Date

A copy of this Document shall be as valid as the original.