

Psychological Associates

Arlington • Falls Church
P.O. Box 2036 Falls Church, VA 22042
Fax 703.859.7675

Risa Broudy, Ph.D.
Phone 703.965.7477

Bronwen Rankin, Ph.D.
Phone 703.424.2909

CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

Client Name _____

Provider Name _____

Persons, Agencies or Providers to whom disclosure is to be made _____

Address _____

Phone Number _____ Fax Number _____

For Purpose of (check all that apply):

- Receiving information to benefit and inform:
 - Treatment Planning
 - Psychological Evaluation
 - Educational Planning
- Disclosing:
 - Testing Results and Recommendations
 - Testing Report
 - Treatment Impressions
 - Treatment Summary
 - Treatment Record

Only information directly relevant to the purpose of the communication will be disclosed.

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential healthcare records or information. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

This consent expires within 60 days (date) _____

Signature of client (or person acting for client)

Date

Printed name

Relationship to client (if necessary)