Location address:

Old Georgetown Office Park
7990 Old Georgetown Road
Suites 9-B, 10-B and 10-A
Bethesda, MD 20814

THE BETHESDA GROUP
PSYCHOLOGICAL SERVICES, LLC

Mailing address:

Old Georgetown Office Park
7960 Old Georgetown Road
Suite 10-B
Bethesda, MD 20814

Release of Information Authorization Form

When completed and signed by you, this form authorizes the release and exchange of protected information from your clinical record to the person(s) you designate.

I, (your name)________________________________, authorize (clinician) ________________________________ and his or her administrative and clinical staff to release, discuss, and disclose case information (Provide a detailed description of the information you want disclosed):

____

____

This information should only be exchanged with: (name of person with whom the information is to be exchanged).

Name: Contact Information:

____

____

I am requesting my clinician to release this information for the following reasons: ("At the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

____

____

This authorization shall remain in effect until (fill in a date or event that relates to the individual or the purpose of the use or disclosure):

____

____

You have the right to revoke this authorization, in writing, at any time by sending written notification to the office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand my provider generally may not condition psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

______________________	______________________	______________________
Printed Name of Signer	Client name (if minor)	Relationship to client

X____ ______________________

Signature of Client, or of Legal Representative, or of Parent for Minor Child Date

If the authorization is signed by a personal representative of the patient, a description of the such representative's authority to act for the patient must be provided.

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