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AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____

DOB: _____

I authorize: Maia Deubert, Psy.D.

_____ to exchange information with

_____ to release information to

_____ to receive information from

NAME OF PERSON, ORGANIZATION OR INSTITUTION

ADDRESS AND/OR PHONE NUMBER

The following information:

_____ Medical Records

_____ Behavioral Report

_____ Psychiatric Records

_____ Education/Academic Records

_____ Psychological Evaluation

_____ Teacher's report

_____ Neuropsychological Evaluation

_____ Verbal Exchange

_____ Other information

For the Purpose of: _____

PATIENT SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

Release is valid for (circle one): ONE YEAR TERMINATION OF TREATMENT

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have already taken action in reliance on the authorization. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy rule. (That is, once I have given -per your authorization- a copy of select clinical records to, for example your physician, I am not liable in case that the physician discloses it to someone else.)

Release Revoked: ____/____/____