MAIA S. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
1489 CHAIN BRIDGE ROAD, SUITE 203
MCLEAN, VA 22101
703 • 447 • 6788

# 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
______ Psychiatric Records
______ Psychological Evaluation
______ Neuropsychological Evaluation
______ Other information
______ Behavioral Report
______ Education/Academic Records
______ Teacher's report
______ Verbal Exchange

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 HIPPAA 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: _______/_______/________