Megan F. Gerbracht, Psy.D., LLC

Licensed Clinical Psychologist

1489 Chain Bridge Rd., Suite 203 ● McLean, VA 22101● 703.627.9086

Re: _____

DOB:_____

I Authorize Megan Gerbracht, 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

_____ Neurophychological Evaluation

_____Other information

_____Behavioral Report

_____ Education/Academic Records

_____ Teacher's report

_____ Verbal Exchange

_____ Visual/audio recording of therapy sessions

For the purpose of:_____

_____ _____

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 HIPPA 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: _____/_____/_____