Arlene C. Gerson, PhD
Licensed Psychologist
9650 Santiago Rd., Suite 3
Columbia, MD 21045

AUTHORIZATION TO RELEASE OR EXCHANGE INFORMATION

PATIENT INFORMATION

Patient Name: _____
Address:_____
City, State, Zip:_____
Date of Birth:_____
Phone Number:_____ Email:_____

RELEASE INFORMATION TO:

Name of Person/Organization:_____
Address:_____
Fax number:_____Phone number:_____Email:_____

INFORMATION TO BE RELEASED:

I hereby authorize Dr. Arlene Gerson to:

Release Information _____
Obtain Information _____
Exchange information _____

This information may consist of the following:

_____ Psychological test reports
_____ Updates on progress
_____ Medical information and records
_____ Other (please specify)_____

I give consent for this information to be used for

_____Transfer of care _____Continuation of care _____School Planning _____ Continuity of care
_____Other (please specify)_____

ACKNOWLEDGEMENT

As is compliant with HIPAA guidelines, I understand that no information may be forwarded by either party listed in this release or to any other individual or agency without my written consent. I understand that this information may not be redisclosed by its recipient. This authorization may be revoked at any time by my written statement, except to the extent that the authorized persons have already taken action. Consent is automatically revoked 30 days after the termination of the therapeutic relationship, or after one year from the date signed, or under the following conditions (please specify if any):

_____

This consent is given voluntarily and without coercion. I understand that signing this form is not required to receive treatment/services from Dr. Gerson.

_____ _____ _____
Signature of Guardian/Patient (≥ 16 years old) Date Printed Name of Guardian or Patient