POTOMAC PSYCHOLOGICAL CENTER, LLC
21001 Sycolin Road, Ashburn. Va 20147
Telephone (703) 858-7838 Fax (703) 858-9697

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Print full name of person about whom information is being sought/released: _____

The following PPC Staff: _____ Clinical Staff _____ Psychiatrists _____ Medical Records

are authorized to: _____ Obtain from _____ Disclose to

Name(s) and Title(s)	Full Address	
Name of Agency	Phone	Fax

INITIAL each **item** for which you are authorizing disclosure:

____ 1. Attendance Record	____ 7. Financial Information	____ 13. Financial Information
____ 2. Social History	____ 8. Diagnosis	____ 14. Other: _____
____ 3. Psychological Evaluation	____ 9. Treatment/Service Plan	____ 15. Other: _____
____ 4. Medical Evaluation	____ 10. Alcohol/Drug Treatment Records	____ 16. Other: _____
____ 5. Medication Record	____ 11. Progress Notes	____ 17. Other: _____
____ 6. Educational Assessment	____ 12. Group Notes	____ 18. Other: _____

*** Select One**-This authorization ☐ **includes** ☐ **does not include** information placed in my record after the signature date.

Limitations (if any) _____

Reason for Disclosure _____

As the person signing this authorization, I understand that I am giving my permission to the above named provider to obtain and/ or disclose my confidential health care information and my signature is not a requirement for receiving services. I also understand that once the information is disclosed, Potomac Psychological Center, LLC is not responsible for redisclosure. A copy of this authorization will be given to me and the original will be included in the health care record. This authorization will expire (1) year from the date signed, or indicate a specific date, event or condition_____

I understand that I have the right to revoke this authorization at any time, but that I cannot revoke information already released in accordance with the authorization. My revocation is not effective until delivered in writing to the Potomac Psychological Center, LLC

Date	**Client's Full Signature**	**Last 4 digits of SSN**	**Date of Birth**

Date	Parent, Legal Guardian or Legal Representative Signature	Authority of Legal Representative to sign for client

Date	Staff/Witness Signature

A copy of this authorization has been given to the individual or his/her representative Staff Initial _____ Date _____

NOTE: This information may be protected by federal regulations concerning alcohol and drug abuse patient records (42 CFR, Subchapter A, Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by such regulations. These regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Date of Revocation: _____

POTOMAC PSYCHOLOGICAL CENTER, LLC

REVOCATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ hereby revoke this Authorization for
(print full name of person revoking authorization)

Release of Information effective _____. I understand any information already released will not
Date
be affected by this revocation.

_____	_____	_____	_____
Date	Client's Full Signature	SSN	Date of Birth

_____	_____	_____
Date	Parent, Legal Guardian or Legal Representative	Authority of legal representative to sign for client

_____	_____
Date	Staff/Witness Signature