Loudoun Psychological Services

217 S. King Street, Leesburg, VA 20175
107 Carpenter Drive, Suite 210 Sterling, VA 20164
Telephone (703) 297-4368 Fax (571) 512-7955

AUTHORIZATION FOR THE RELEASE OF INFORMATION

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

The Following LPS staff: _____ Eric Zelsdorf, PsyD _____ Sofia Graham, PsyD _____ Najwa Mohamed, PsyD

_____ Alex Gibson, PsyD _____ Donald Jaskulske, PsyD _____ Andrew May, MA

_____ Jessica Raasch, MA _____ Elizabeth Stevens, MEd _____ Krina Patel, MA

_____ Michael Arthur, MA _____ Ashley Scott, MA _____ Laeli Sharifi, MA

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
_______2. Social History
_______3. Psychological Evaluation
_______4. Medical Evaluation
_______5. Medication Record
_______6. Educational Assessment
_______ 7. Vocational Assessment
_______ 8. Diagnosis
_______ 9. Treatment/Service Plan
_______10. Alcohol/Drug Treatment Records
_______11. Alcohol/Drug Test Results
_______12. Progress Notes
_______13. Group Notes
_______14. Discharge Summary
_______15. Financial Information
_______16. Lab Reports
_______17. Court Ordered Evaluation
_______18. Other (specify)____________

* **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 provider named above 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, the LPS staff 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 LPS.

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 ________