Sarah A Leffler, MSW, LCSW, LLC
1600 Prince Street, #102
Alexandria, VA 22314

Authorization to Release/Disclose Health Care Information

Name of Client: _____
Please Print

Date of Birth: _____

I hereby authorize:

Name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Email Address: _____

to release reciprocally copies of the following confidential information and/or abstract information including medical, psychiatric and/or psychological information that may be protected under HIPAA.

TO: Sarah A Leffler, MSW, LCSW, LLC
1600 Prince Street #102
Alexandria, VA 22314

I specifically authorize the release of the following information:

_____ Medical History/Intake Information

_____ Progress Notes

_____ Consultation Reports or Notes

_____ Verbal Discussion of Care

_____ Other: _____

The requested information is about health care provided during the following approximate time frame:

_____

You have the right to withdraw your consent for release of information at any time with written notice to the office of Sarah A Leffler, MSW, LCSW, LLC.

I have read the above statement. I understand that the materials being released/requested will be kept strictly confidential. Information may only be used for the development of/continued therapeutic treatment and no one other than the above parties may have access.

_____ _____
Signature of client or parent/guardian Date

_____ _____
Signature of client or parent/guardian Date

_____ _____
Witness Date