McLean Psychiatric Services LLC
1307 Dolley Madison Blvd, Suite 3C
McLean, VA 22101
Phone: (703) 336-2406 Fax: (703) 646-7584

Release of Information Form

Patient's Name:

Date of Birth:

I hereby give my consent and authorize McLean Psychiatric Services LLC to **RELEASE**:

My (or the patient's) **personally identifiable health information** to the person or organization below:

Name/Organization:

Street:

City: **State:** **Zip Code:**

Phone Number:

Fax:

Purpose of Disclosure (e.g. communication regarding my / the patient's treatment):

This authorization to release medical records and my personal health information includes but is not limited to progress notes, evaluations, consultations, tests, and demographic information, related to my / the patient's medical history, mental health history, or substance abuse history--**unless limitations on the information to be disclosed is specified:**

Patient or Parent / Guardian Signature:

Date Signed:

This authorization will remain valid for one year from the date of signature unless revoked by me, which I may do at any time. I understand this information is protected by federal and state confidentiality laws and may not be disclosed without authorization or unless required or permitted by law.