Ann O'Malley, Ph.D., LLC 200 Park Ave, Suite 304 · Falls Church, VA 22046

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Consent for Release of Information

I, _____, authorize the communication of clinical information between Dr. Ann O'Malley and: (fill in all that apply)

Telephone:

Primary care physician: _____

(____)_____

Psychiatrist: _____

(____)_____

School/Teacher: _____

(____)_____

Individual therapist: _____

(____)_____

Family/couples therapist: _____

(____)_____

Other ( ): _____

(____)_____

Other ( ): _____

(____)_____

Communication may include direct verbal communication, clinical documentation including inpatient and outpatient treatment notes, discharge summaries, testing and laboratory results, and similar clinically relevant materials.

I understand that I may withdraw this consent at any time by submitting a request in writing to Dr. O'Malley. Please note that once the requested information is disclosed pursuant to this Authorization, Ann O'Malley, Ph.D. will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

_____

_____

Signature of Client or Legal Representative Date Signed

_____ _____

Print Client Name Date of Birth

_____ _____

Print Name of Legal Representative Relationship to Client