Nicole K. Albertson, Psy.D., LLC
301-663-3350

Release of Information

I hereby authorize Nicole K. Albertson, Psy.D. to exchange information about

_________________________________ with ____________________________________

_________________________________ ____________________________________

(Client's name and DOB) ____________________________________

(Name, address, phone of person/organization to receive information)

Purpose of release of information:

___ Further mental health care
___ Treatment Planning
___ Outpatient treatment plan
___ Other ________________
____

Nature of the information to be released:

___ Dates of service
___ Verbal exchange
___ Treatment summary
___ Payment information
___ Full records
___ Other ______________________

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records and information and the implications of its release and is made voluntarily on my part.

I understand that I may revoke this consent at any time within one year except to the extent that action based on this consent has been taken. This consent will expire automatically after one year from the date on which it is signed or upon the fulfillment of the above purposes or on _______________.

I also know that I have the right to ask for and receive a copy of this authorization. I agree that a photocopy of this authorization will be as valid as the original.

____ ______________________
Signature of Client or of Parent or Guardian Date

____ ______________________
Signature of Therapist Date

____ ______________________
Signature of Witness Date