**Jessica L. Cardwell, Psy.D., LLC**
503 Carlisle Dr., Suite 225-E
Herndon, VA 20170
(571) 335-0893

## Release of Information (Optional)

Client's Name: _____ DOB: _____

I, _____, authorize Jessica L. Cardwell, Psy.D., LLC

to: _____ (send) _____ (receive) _____ (send & receive) information from:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone:_____ Fax:_____

*Please check all that apply:*

_____Treatment Information (Verbal) _____Psychological Testing Results (Verbal)
_____Treatment Information (Written) _____Psychological Reports (Written)
_____Entire record, except progress note _____ *Psychotherapy Notes
_____Other, specify _____
_____

*A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.
*I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.*

Your relationship to client: ___Parent/Legal guardian ___Personal representative
___Other (describe)_____
If you are the legal guardian or representative appointed by the court for the client, please attach a copy of your authorization to receive this protected health information.

**Parent/Guardian/Client Signature:**_____ **Date:**_____

**Printed Name of Client:** _____