# CONFIDENTIAL — AUTHORIZATION TO RELEASE AND/OR OBTAIN RECORDS

| Client Name: | #: | Birth Date: |
|---|---|---|

| COMMUNICATION FROM: | COMMUNICATION TO: |
|---|---|
| **LISA DREXLER, Ph.D.**<br>5480 Wisconsin Avenue, Suite #204<br>Chevy Chase, Maryland 20815<br><br>Telephone: (301) 656-8891 | (Program/Person/Agency) _____<br>(Address) _____<br>_____<br>(City/State/Zip Code) _____<br>(Telephone) _____ |

**AS SPECIFIED AND AGREED TO BELOW:**

1. I understand I may revoke this consent to release information at any time, except to the extent that action has been taken in reliance thereon, and that upon fulfillment of the stated purpose(s), this consent will automatically expire. Unless sooner revoked or fulfilled, this consent will expire one year from the date signed.
2. Information provided by other professionals to Dr. Lisa Drexler will be held strictly confidential and will not be released without my expressed written consent.
3. I understand that admission or continued treatment by Dr. Lisa Drexler is not conditional upon my consenting to release this information.
4. I realize this communication will reveal that I am in therapy with Dr. Lisa Drexler to the person contacted.
5. The benefits and disadvantages of release of this information have been discussed with me.
6. My release of the information is not intended and shall not be construed as a waiver of my privilege as to the confidentiality of therapy records or my privilege as to the privacy of the communications with my therapist.
7. The information here authorized for release is with my express understanding that the person or entity to which it is released is not authorized to re-disclose the released information without my express written consent or as otherwise required by law.

**INFORMATION TO BE RELEASED AND/OR OBTAINED MAY INCLUDE ANY OF THE CHECKED BOXES:**

- ☐ Alcohol & Drug Usage History
- ☐ Medical History
- ☐ Psycho-Social History
- ☐ Psychiatric History
- ☐ Continuing Care Planning
- ☐ Change in Condition/Status
- ☐ Spiritual Assessment
- ☐ Legal Issues
- ☐ Psychological Testing / Personality Assessments
- ☐ Other (Specify): _____

**THIS INFORMATION WILL BE IN THE FORM OF:**

- ☐ An Abstract
- ☐ Discharge Narrative Summary
- ☐ Verbal / Telephone Conversation
- ☐ Written Report
- ☐ Lab and Test Results
- ☐ Other (Specify): _____

**METHOD(S) FOR RELEASING INFORMATION:**

- ☐ Verbal/Telephone
- ☐ Written/Photocopy
- ☐ Other (Specify): _____

**PURPOSE OF DISCLOSURE:**

- ☐ To Provide Ongoing Treatment
- ☐ To Facilitate Your Insurance Reimbursement
- ☐ To Coordinate Treatment Efforts with Family/Concerned Persons
- ☐ Other (Specify): _____

| SIGNATURES: | |
|---|---|
| Patient Signature Date | Witness Signature Date |

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