Bethesda Psychological and Family Services, PLLC
Matthew S. Burgess Leary, Ph.D.

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Authorization for Release of Information or Records

I, _____, hereby authorize Bethesda Psychological and Family Services, LLC to RELEASE ___ or OBTAIN ___ or EXCHANGE ___ with:

_____
Name of Person or Organization receiving or providing records

Address_____

Phone_____ Fax_____

I authorize the release or exhange copies of all clinical records or other information about my (self/ self and partner / child / family) pertaining to evaluation and/or treatment during the period from _____ to _____. These records or information are required for the specific purpose of _____, and the information REQUESTED or RELEASED is limited to _____.

* Psychotherapy notes require a separate release.

I understand that I may withdraw my written consent (except to the extent that action has already been taken) at any time by writing or, if I am unable to write, orally advising my therapist. I understand that under most circumstances I may look at the records and/or material to be released. I understand that I give my permission for the records and/or information to be obtained from or released to only the person or organization listed above solely for the purposes stated above. I understand that my authorization is valid for one year from the date signed below unless I withdraw my consent prior to that time.

Signature of client(s): _____

Signature of Parent / Legal Guardian: _____
(if client is a minor child)

Date: _____

_____ _____
Matthew S. Burgess Leary, Ph.D. Date