Laila El-Asmar, LCSW-C, LLC

4828-B Bethesda, MD 20814
(202) 701-0051
Laila.elasmarlcswc@gmail.com

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT _____ DOB_____

I AUTHORIZE _____

(NAME)

_____

(ADDRESS)

TO RELEASE TO _____

(NAME)

_____

THE FOLLOWING INFORMATION:

_____**MEDICAL RECORDS**
_____**EDUCATION/ACADEMIC RECORDS**
_____**PSYCHIATRIC EVALUATION**
_____**PSYCHOLOGICAL EVALUATION**
_____**VERBAL EXCHANGE**
_____**TREATMENT PLAN**
_____**OTHER INFORMATION**
_____**NEUROLOGICAL EVALUATION**
_____**BEHAVIORAL REPORT**
_____**TEACHER/SCHOOL ADMINISTRATION REPORT**
_____**E-MAIL EXCHANGE**
_____**SUBSTANCE ABUSE EVALUATION**

I understand that I have the right to information about my treatment. I understand that this information may not be disclosed without my authorization. **This consent is valid for one (1) year and may be revoked anytime by written or oral communication to Laila El-Asmar, LCSW-C, LLC.** I certify that this form has been fully explained to me and that I understand its contents.

_____ _____
Client/Parent/Guardian Date

_____ _____
Witness Date