THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

DEPARTMENT OF PSYCHOLOGY

AUTHORIZATION FOR RELEASE OF INFORMATION

TO OR FROM THE MELTZER CENTER

Client Name: _____ Client Number: _____

Date of Birth: ____/____/_____

The Meltzer Psychological and Community-based Services Center has my permission to **provide/obtain/exchange** (circle one) verbal or written information relevant to my treatment **to/from/to and from** (circle one):

Name: _____

Address: _____

_____

Phone Number: (_____) _____ - _____

CHECK ALL THAT APPLY:

_____ Psychiatric Evaluation	_____ Individualized Treatment Plan
_____ Psychological Evaluation	_____ Progress Notes
_____ Psychosocial Summary	_____ Discharge Summary
_____ Psychoeducational Evaluation	_____ Individualized Education Plan
_____ Medication Information	_____ Medical History

This information is to be used for the purpose of _____ and cannot be redisclosed without my written authorization. I understand that I have the right to review my medical record and that I may revoke this authorization in writing at any time.

_____ _____

Client/Parent Signature Date

EXPIRATION OF AUTHORIZATION

This authorization will expire 60 days from the date signed above.

The District of Columbia Mental Health Information Act requires the following notice: **The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Act of 1978.** Disclosures may only be made pursuant to a valid authorization by the client or as provided in the Title III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.