CLAUDIA I. SALAZAR, PSY.D
LICENSED PSYCHOLOGIST
1313 L St NW, Suite #140. Washington, DC 2005
Phone/Fax: (202) 595-1834
claudiasalazar.psyd@gmail.com

Authorization for the Release and/or Exchange of Information

I, _____, hereby give permission to *Claudia Salazar, Psy.D* to:

____ Release protected information and/or ____ Exchange protected information with:

_____
Name of Primary care physician, attorney, counselor, therapist, parent

_____
Complete Address

Phone ( )_____ FAX ( )_____

Information to be disclosed/exchange (Check all that apply)

____ Diagnostic/ Assessment & Treatment Recommendations
____ Psychiatric Evaluation and Medication Notes
____ Treatment notes
____ Discharge Summary and Recommendations
____ Other

Records for the period (dates) _____to _____

Form in which information should be released: ____ verbal _____written

The purpose of such disclosure is:

____ To facilitate continuity of care and treatment planning
____ Third party reimbursement and processing of benefit claims
____ Other

This authorization shall remain valid unless revoked but will expire in one year after signing.

I understand that:

a) I am under no obligation to sing
b) I have the right to inspect and copy any information released
c) I may revoke this consent at any time and such revocation must be in writing
d) Any release of information completed before a revocation is protected by this consent

Name: _____Date of Birth_____

Signature: _____ Date: _____