Stacie B. Isenberg, Psy.D., PLLC
5028 Wisconsin Ave. NW, Suite 260 • Washington, DC 20016
202.669.3564 • drsbisenberg@gmail.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Patient Address: _____

_____

Date of Birth: _____

I hereby authorize Stacie B. Isenberg, Psy.D., PLLC to release my/my child's protected health information to:

Name/Institution _____

Address _____

_____

Telephone _____

Fax _____

E-Mail _____

Data shall include:
____ all records
____ information from therapy notes/treatment that Dr. Isenberg determines to be relevant for the purpose stated below
____ substance abuse information
____ psychological testing records
____ other (specify) _____

Specific purpose:
____ continued/coordinated care
____ other (specify) _____

I understand that if the aforementioned records pertain to drug or alcohol abuse treatment, HIV/AIDS testing, treatment, or related illness that such information will be released pursuant to this authorization.

I understand and agree that 1) I have a right to inspect my Protected Health Information (PHI); 2) I may revoke this authorization in writing at any time; 3) this authorization will expire 365 days from the date written below; 4) District of Columbia Law prohibits re-disclosure of Protected Mental Health Information by the recipient without my consent; 5) Stacie B. Isenberg, Psy.D., PLLC may disclose my PHI without my consent only in specific circumstances authorized by law; and 6) Stacie B. Isenberg, Psy.D., PLLC may refuse to disclose or allow my inspection of part or all of my PHI if she believes that it is necessary to protect me or someone else from psychological or other harm.

This consent form has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled.

_____ _____
Name of Patient Name of Legal Guardian (if applicable)

_____ _____
Signature (Patient or Legal Guardian) Date