Susan Perkins, Ph.D.
405 North Washington St., Suite 104
Falls Church, VA 22046
Phone 703-534-1095
Fax 703-533-9433

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: ____

DOB: ____

I authorize Susan Perkins, Ph.D.

________ to exchange information with

________ to release information to

________ to receive information from

____
Name of Person, Organization, or Institution Phone Number

____
Address

The following information:

_____ Medical Records
_____ Education/Academic Records
_____ Psychiatric Records
_____ Psychological Evaluation
_____ Neurological Evaluation
_____ Behavioral Report
_____ Teacher's Report
_____ Verbal Exchange
_____ Other Information

Approximate Dates of Service: ____

For the Purpose of: ____

____ ____________________
Signature of Client Date

____ ____________________
Signature of Parent/Guardian Date

____ ____________________
Witness Date

Release Valid For: One Year Termination of Treatment

Revoked (please circle one)