ELLIS PSYCHOLOGICAL SERVICES, LLC
1487 CHAIN BRIDGE ROAD, SUITE 303
MCLEAN VA. 22101
P: 703-790-0088
F: 703-940-0684

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____Date of Birth:_____

Approximate Dates of Service:_____

I authorize Dr. Mary A. Ellis, Licensed Clinical Psychologist

____ to exchange information with ____ to release to ___ to receive from

Person, Organization, Or Institution:_____

Address:_____

Phone:_____Fax:_____

The following information:

____Education/academic Records ___ Psychological Evaluations/Testing

___ Behavioral Report ___ Teacher's Report

___ Verbal Exchange ___ Medical Records

___Treatment Plan/Summaries ___ Progress/Participation in Treatment

___Other information ___ Assessment Summaries

For the Purpose of:_____

Release is Valid for (circle one): One Year Termination of Treatment Revoked

I understand that I can revoke or cancel this Authorization for Release of Information at any time.

Signature:_____Date:_____

Witness:_____Date:_____