Authorization for Release of Information For Trisha Souders Rubin, L.C.S.W.

Regarding Client____

D.O.B_____________________ Address____

I Authorize Trisha Souders Rubin, 10400 Eaton Place, Suite 200, Fairfax, VA 22030

_____ To Exchange Information With

_____ To Release To

_____ To receive From

____

(Name of Person, Organization, or Institution)

____

(Address)

The Following Information: _____Medical Records; _____Education/Academic Information; _____Psychiatric Records; _____Psychological Evaluation; _____Neurological Evaluation; _____Verbal Exchange; _____Other Information

Approximate Dates of Release____

For the Purpose of:____

________________________________ ______________________________

(Signature) (Date)

Release is Valid for: One Year or Termination of Treatment (Circle One)