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CHILD, ADOLESCENT AND ADULT PSYCHIATRY

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## AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____

DOB: _____

I authorize: Catherine L. McCarthy M.D., PLLC
6723 Whittier Ave., Suite 403
McLean, Virginia 22101

_____ to exchange information with

_____ to release to

_____ to receive from

_____
Name of Person, Organization, or Institution

_____
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 Date

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

**Revoked**