Lisa A. Lenhart, PhD, LLC 100 Park Ave., Suite 105 Rockville, MD 20850

Authorization for Use/Disclosure of Information Of Psycho-Educational and/or Psychological Services

Name of person receiving services:
Birth Date:

I hereby authorize and consent to the use/disclosure by Lisa A. Lenhart, PhD of Protected Health Information in the following form (Check all that apply):

☐ Written Reports ☐ Verbal Exchange ☐ Email Exchange ☐ Other:

Indicate to whom you would information exchanged:

NAME	**ADDRESS/PHONE**
Self/Parent:	
Physician:	
School or Funding Agency:	
Other:	

This protected health information is being used or disclosed at your request for contact with and/or follow-up with participating professionals or schools, and/or for insurance/reimbursement purposes.

I hereby release Lisa A. Lenhart, PhD from legal responsibility or liability for information released pursuant to this Authorization. I also understand that I may withdraw this consent at any time with written notification to Lisa A. Lenhart, PhD.

This authorization shall be in force and effect until 1 year from the date of this document at which time this authorization to use or disclose this protected health information expires.

_____ _____
Signature of Person Receiving Services or Legal Representative Date

_____
Relationship to Person Receiving Services