Information Sheet

Name _____

Address _____

Phone(s) In case of tele-consult failure: _____

Other(s)_____

E-mail _____

ONLY provide your e-mail if it's OK to use it to (1) communicate about scheduling, (2) send you supplemental info for sessions.

_____

Date of Birth

Emergency Contact (in case a lack of safety issue arises)

_____

Name Contact Phone

Your Providers Address (if you know it)

Dr. _____

Dr. _____

Dr. _____

_____

Who referred you?

It's customary to inform providers that you're in treatment with me. **Details aren't shared**, unless specific collaboration is warranted. ***Please sign the attached*** for this.

Thank You,
Meredith Cary, PsyD

Authorization Form

(in compliance with HIPAA)

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize Meredith Cary, PsyD to release information about the beginning and end of my treatment with her and other information that might be helpful to my other healthcare providers in my overall treatment.

This information should only be released to the healthcare providers I listed on Dr. Cary's "Information Sheet" as my providers.

I am requesting my psychologist to release this information for the following reasons- at the request of myself.

This authorization shall remain in effect until we have completed the brief, time limited psychotherapy sessions; however, except as provided below, the authorization shall be in effect no longer than 60 days from the date you sign this form.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Additionally, you may not revoke where an authorization is executed in connection with your obtaining a life or noncancellable or guaranteed renewable health insurance policy, in which case the authorization shall be specific as to its expiration date which shall not exceed 2 years from the date of the policy; or where an authorization is executed in connection with your obtaining any other form of health insurance in which case the authorization shall be specific as to its expiration date which shall not exceed 1 year from the date of the policy.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

Meredith Cary, PsyD
1234 Nineteenth Street, #901
Washington, DC 20036
(703-447-8011)