Debbie Beach, LCSW
405 N. Washington Street, #104
Falls Church, VA 22046
Debbiebeach4@gmail.com
202-415-6242

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: ____

DOB: ____

I authorize Debbie Beach, LCSW to exchange information with:

____

Name of Person, Organization, or Institution Phone Number

____

Address

The following information:

_____ Medical Records	_____ Behavioral Report
_____ Education/Academic Records	_____ Teacher's Report
_____ Psychiatric Records	_____ Verbal Exchange
_____ Psychological Evaluation	_____ Other Information
_____ Neurological Evaluation	

For the Purpose of: ____

____ ____________________

Signature of Client Date

____ ____________________

Signature of Parent/Guardian Date

____ ____________________

Witness Date

Release Valid Until (please circle one):

One year | Termination of treatment | Revoked