Linda Cherry, PsyD, CPT
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The Mosby Tower
10560 Main Street LL15, Fairfax, VA 22030

Client Name ____ DOB_______________________

Date_____________ Phone ( ) ____________________ Email: ____________________________

I, __________________________(Client Name), authorize Cherry Wellness LLC/Linda Cherry, PsyD:

___Disclose to ___Obtain From

In the Following Manner: ___Electronic ___Oral ___Written

Name of Person / Agency: ____

Address: ____

City:______________________________ State: _______ Zip:_____________________

Phone: ______________________________E-Mail Address:____________________________________

Relationship to Client:____

The Following Information:

___Presence in Treatment
___Progress in Treatment
___Results of Physical Exam
___Medical History / Current Medical Status
___Laboratory Test Results
___Legal Status
___Biopsychosocial Assessment
___Treatment Plans
___Psychological Assessment
___Psychiatric History & Assessment
___Discharge Planning / Summary
___Aftercare Recommendations
___Employment Information
___Family Information
___Other

I understand my records are protected under Federal Regulations (42CFR, Part2) and may not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it and that, in any event, this consent expires automatically one year from the date signed, otherwise unless specified here. Expiration ____

____ __________________
Client Signature Date

I have explained and / or read this Consent to Release Information to the client.

____ __________________
Staff Signature Date

Rev 2/18