Lorraine B. Wodiska, PhD, CGP, FABPP, FAGPA
Licensed Psychologist

6014 28th Street North
Arlington, VA 22207

703 536-5545
lwodiska@gmail.com

Authorization to Disclose Form

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

1. **Permission is given to:**
Lorraine B. Wodiska, PhD **_x____to release information**
_x___to obtain information

2. **Name of Patient:**

3. **Information is to be released to or obtained from:**

4. **Purpose or need for disclosure: Coordination of Individual and Group Treatment**

5. **Extent or nature of information to be disclosed: Discretionary**

6. **This is a: _____single disclosure _x____continuing disclosure**

7. **I understand that I may revoke this consent at any time. In any event this consent expires automatically as described below.**

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

9. **Signature of Patient:**

____Date:__________________

10. **Signature of Psychologist:** **Date:**
Lorraine Wodiska, PhD
Lorraine Wodiska, PhD

11. **Expiration Date:**