Gonzalo Laje, M.D.

CONSENT FOR RELEASE OF PATIENT INFORMATION
(School version)

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Social Security #: _____

I Hereby Authorize _____
(Teacher/Counselor/School psychologist – please include all that apply)

Phone #: _____ Fax#: _____
(Authorized school's phone number & fax number)

Address: _____
(Authorized school's address)

to release my records to:

Gonzalo Laje, M.D.
5480 Wisconsin Ave.
Suite 228
Chevy Chase, MD 20815
Phone: 301-576-6044 Fax: 301-576-1645

Data shall include: ☐ all records pertaining academic, behavior and psychological/educational testing information.

☐ other (specify) _____
(Nature and extent of data to be released)

Specific purpose: assessment and/or treatment

This consent shall be valid for one year.

This consent form has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I also acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

Signature (Patient / Parent / Guardian) _____ Witness _____

Printed name _____ Printed name _____

Date _____ Date _____