

Caroline M. Sehon, M.D.
Child, Adolescent and Adult Psychiatry
6917 Arlington Road, Suite #210
Bethesda, MD 20814
Tel (301) 642-6162

CONSENT TO MENTAL HEALTH INFORMATION DISCLOSURE

I, _____ hereby consent to and authorize Dr. Caroline M. Sehon, MD, to obtain from (X) and/or disclose to (X)

Address: _____

the following information regarding _____

DOB _____

- (X) Psychiatric Information, reports
- (X) Psychological/educational testing reports
- () School reports
- () Medical or laboratory information
- () If hospitalized, the hospital team may be contacted
- () Other _____

The purpose of this disclosure is to facilitate collaborative care.

I understand that I may revoke my consent at any time, except to the extent that action has been taken in reliance upon it. In any event, it will expire no later than twelve (12) months from the date of consent.

_____ authorization for one-time only disclosure

X authorization for ongoing disclosure

By typing your name below, you are providing Dr. Sehon with your electronic signature, thus saving you the step of printing and manually signing this form. Thank you.

Patient, Parent/Guardian _____
Date _____