

RENE LAJE, Ph.D., LICSW

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**CONSENT FOR RELEASE AND EXCHANGE OF PATIENT INFORMATION**

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

I Hereby Authorize: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax#: \_\_\_\_\_

(Authorized person's phone number & fax number)

Address: \_\_\_\_\_

(Authorized person's address)

to release my patient record to and exchange information with:

Rene Laje, Ph.D.  
4545 42<sup>nd</sup> Street, NW  
Suite 200  
Washington, DC 20016  
Phone: 301-455-4149 Fax: 301-576-1645

Data shall include:  all records pertaining clinical, substance abuse and HIV 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

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date