**Authorization for Release and Exchange of Confidential Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the following person/organization to exchange relevant clinical information about me with Dr. Melinda Moore, Ph.D.:

Name of person\organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I give permission for the following information to be disclosed:**

\_\_ Psychotherapy Treatment Summary (intake and/or termination)

\_\_ Progress Notes

\_\_ Psychological Assessment Report

\_\_ Psychiatric or Other Medical Treatment Intake and Discharge Summaries

\_\_ Ongoing Consultation

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**for the purpose of:**

\_\_ coordination of care \_\_ treatment planning \_\_ further mental health evaluation or treatment

**This information may be transmitted by**: \_\_ fax \_\_ telephone \_\_ U.S. mail

**I understand that I may revoke this consent at any time. Upon fulfillment of the above this consent will automatically expire without my express revocation six months from the date on which it is signed. I understand that information shared by Dr. Moore may be redisclosed by the above recipient and is no longer protected the HIPAA Privacy Rule.**

Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_/\_\_\_\_/\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_