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CONSENT TO RELEASE INFORMATION

I, hereby authorize Angela E. Moskovis, Ph.D. and/or (name of person/organization, address, phone number) _____to disclose information and/or records regarding (name of client) _____ The following information may be disclosed:

All pertinent records/information Psychological/Psychiatric treatment reports_____

Medical records_____

Educational/School records_____

Diagnostic impressions_____

Psychological testing reports_____

Hospital records_____

Family history_____

Laboratory tests_____

Other (describe)_____

Disclosure of records is required for the following purposes:

Psychological treatment Educational planning ____

Medical evaluation Court request_____

Other

(describe)_____

_____

This consent shall terminate as of (date)_____

Date Name_____

Signed_____

Witness_____