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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____