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AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

I, ______________________________ hereby authorize Richard Moyer, Psy.D. to discuss and disclose information and psychological records (including developmental history, diagnosis drug and alcohol history, medical history, AIDS/HIV information, progress notes, assessment information, and any and all other information relevant to my treatment) with the following individual and/or company representative:

Name: ____

Address: ____

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Phone: ______________________ Fax: ______________________

Further, I authorize this individual or company representative to provide Dr. Moyer with any and all information, which may be relevant to my treatment. I understand that this disclosure is required for the purposes of my further treatment with Dr. Moyer, or is occurring upon my request. I acknowledge that I have been advised of the benefits and detriments of such disclosure. This consent is freely given and is subject to revocation by myself at any time expect to the extent that action has been already been taken in reliance thereon, and if not earlier revoked, it shall terminate upon the termination of my treatment with Dr. Moyer, without express revocation. I release Dr. Moyer from any legal liability arising from the release of this information. I further understand that this information may be communicated via fax machine and that I may expressly forbid that mode of communication should I so indicate.

Fax Authorization ☐ Yes ☐ No

AIDS/HIV Authorization ☐ Yes ☐ No

Client Signature: ______________________ Date: ____________

Therapist Signature: ______________________ Date: ____________