

Release of Information

I, _____, consent to allow Dr. Roger Moore of The Center for Psychological Wellness to release and/or exchange information regarding the patient, _____.

This information will include:

_____ Procedures	_____ Psychological Testing
_____ Medical Records	_____ Therapy Notes
_____ Educational Records	_____ Discharge Summary
_____ Other _____	_____ All of the above

To/With (Name and Address of Person/Agencies)

I understand that this information will be used in the client's best interests to benefit current psychological evaluation and/or treatment. I understand that the information exchanged will be handled in a professional and confidential manner.

It is the policy of The Center for Psychological Wellness to not release the materials provided by physicians from outside this office regarding the patient's former or current care. You may obtain second party records by contacting the source directly. Second party records will only be released when such records are no longer available from the original source.

I also understand that I may revoke this consent at any time except to the extent that action based on this consent has already taken place. This consent expires in 360 days.

Signature: _____ Witness: _____

Relationship to Patient: _____ Date: _____