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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize Kari Moskowitz, PhD, a psychologist in private practice at the above location, to release, and exchange information with:

_____
(Name of individual(s) and/or agency from whom information is to be obtained)

at (address and/or phone)_____

about myself or my child .

Additionally, I consent to _____ sharing,
(Same name of above professional individual or agency)

releasing, and exchanging information with Kari Moskowitz, PhD.

The information being released and shared will be used for treatment planning and co-ordination.

I understand that I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically by _____.
(Date of expiration)

_____ _____
Signature of Client/Parent (if client is a minor) Date