Wendy Moyer, LMFT Counseling Services

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Phoenix, AZ 85062

480-980-7926

Authorization Form for Release of Information

This form, when completed and signed by you, authorizes me to discuss and/or release information from your clinical record to the person you designate.

I authorize my therapist, **Wendy Moyer, LMFT** to discuss and/or release the following information on behalf of : **Client Name** (Please Print):

_____

[ ] Protected Health Information [ ] Intake Summary [ ] Psychotherapy Notes

[ ] Thank you for Referral Letter [ ] Testing Results [ ] Other _____

This information should only be discussed or released to (person(s) to whom the information is to be released):

Name_____

Address_____

Phone/Fax #_____

The authorization shall remain in effect until _____(Date), not to exceed 1 year from today's date.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address or delivering to me in person. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization was obtained was a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim or:

_____

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided for me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by HIPAA Privacy rule.

_____ Signature of Client
_____Signature of Spouse, Partner, Parent or Guardian

Printed Name:_____Printed Name:_____