LYNNE MOSER, LCSW

LICENSED CLINICAL SOCIAL WORKER

917.605.1006

Consent for Release of Information

I, _____, authorize Lynne Moser, LCSW

to disclose/receive from _____ the following information:

_____

_____

_____

_____

The purpose of the disclosure authorized herein:

_____

_____

_____

I understand that my records are protected under HIPAA regulations governing confidentiality and cannot be disclosed without my written consent unless provided for in the regulations. I understand that I may revoke this consent at any time by submitting a request in writing to Lynne Moser. This consent expires one year from today on _____.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian/Authorized Representative Date

THE ATRIUM, 4 TERRY DRIVE, SUITE 11, NEWTOWN, PENNSYLVANIA 18940