CONSENT FOR RELEASE OF INFORMATION

I, ___________________________________, authorize **Lynne Moser, LCSW, LLC** to

disclose / receive from _____________________________ the following information:

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The purpose of the disclosure authorized herein:

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I understand that my records are protected under HIPAA regulations governing confidentiality and cannot be disclosed without my written consent with the exceptions expressed in the regulations. I understand that I can revoke this consent at any time by submitting a request in writing to Lynne Moser.

This consent does not expire.

____ ____________________

Client Signature Date

____ ____________________

Parent or Guardian/Authorized Representative Date