Diane C. Moore, M.A.,L.P.C.
6950 SW Hampton St. Suite 100
Tigard, OR 97223

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's name:(please print) _____
Client's date of birth_____
This Release of Information authorizes Diane Calvin Moore, M.A.,L.P.C., to ___provide ___obtain information about me from/to:

Name/Facility/Agency_____

Street Address_____

City, State, ZipCode_____

Phone_____FAX_____

Relationship to Client:_____

Information to be disclosed: (please initial)
____Treatment Dates/ Discharge Date
____Progress Updates
____History and Physical
____Lab/diagnostic Tests
____Medication Records
____Chemical Dependency Assessment
____Psychiatric and/or Psychological Assessment
____Continuing Care Plans
____Verbal Release Only
____Other Information:

Purpose of Authorization: to provide appropriate clinical and medical coordination of care.

I am entitled to a copy of this Authorization upon request.

Disclosure: I understand that this information provided may be disclosed, per this authorization, either verbally, in-person, mailed, or faxed. I understand that releasing of my records will reveal that I am or have been a client of Diane C. Moore, L.P.C. I understand that my continued care is not conditioned upon signing this authorization. HIPAA Regulations have been provided to me in writing. Revocation: I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

This Authorization expires one year from date of signature, unless revoked earlier in writing.

Signature Date