Move Toward Change, LLC

Authorization to Disclose Information Form

Client Name: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Telephone: _____ Fax: _____ Email: _____

Date of Birth: _____

I authorize the release of my medical records or other health care information (check what to release)

- ☐ intake forms
- ☐ reports
- ☐ billing statements
- ☐ diagnosis
- ☐ clinical session notes
- ☐ correspondence
- ☐ other written information

For dates of services from _____ to _____

Company: _____

Name: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Telephone: _____ Fax: _____ Email: _____

Client Signature: _____ Date: _____

This authorization is valid until: _____ or 1 year from the date of your signature.
date

Address: 11010 Lake Grove Blvd Ste 100-124 Morrisville NC 27560
Phone: 919-659-9833
Fax: 919-375-2070