Shauna K. Moore, **M.S., L.M.F.T.**
AAMFT Approved Supervisor
Certified Integrative Health Coach
I N D I V I D U A L • M A R I T A L • F A M I L Y T H E R A P Y
To everything there is a season.
910-814-9008

Client Authorization to Exchange Information

(Print or write clearly)

I, _____, hereby authorize Seasons Change, PLLC, Shauna K. Moore, MS, LMFT and _____(agency and/or individual name) to exchange information from my clinical records/ or my child's clinical records (Child's name _____).

The purpose for the exchange of information is _____
_____
_____

I place the following limitations on the exchange of information:_____
_____
_____

Individual and/or agency with which exchange of information is to be made:

Name _____Telephone _____
Address _____

I understand that drug and alcohol information is protected information and I give my permission for this information to be disclosed. **Yes____ No____ Initials_____**

I understand that I may revoke this consent in writing at anytime, except to the extent that action has already been taken to comply with it. I waive any time limitations on this release. I understand that without a written request from me to revoke the release, it will remain in effect indefinitely. _____**Initials**

OR

I wish the release to be invalid after_____ **Date** _____**Initials**

_____ _____ _____
Client or Parent's Signature **Date** **D.O.B. of Client**

_____ _____
Witness **Date**