Rich Morey, Ph.D.

Licensed Psychologist---PSY. 12822

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AUTHORIZATION FOR RELEASE OF INFORMATION OR RECORDS

Client Name ______________________________

DOB ____/____/____

I, _______________________________________, hereby give permission to Rich Morey, Ph.D. to:

☐ Disclose information/records to: and/or ☐ Obtain information/records from:

____
(name of physician, psychologist, counselor, attorney, school counselor…)

____
(address, city, state, and zip code)

__________________________ __________________________
(telephone number) (email address)

REASON(S) FOR INFORMATION TO BE RELEASED/OBTAINED:

___Court ___Psychological/Psychiatric Treatment ___Social Security

___School ___Employment ___Physician

Other, Specify ____

_______________________ _______________________

Patient Signature Guardian Signature
(Relationship) ____________

Date ________________ Date ___________________

A copy of this authorization shall be as valid as the original. This release shall be valid for 365 days from the date signed. The patient may revoke this release at any time.

Feb. 2019