April V. Moran, LCSW-C
1122 Kenilworth Drive, suite 100
Towson, MD 21204
EMAIL: aprilvmoran@icloud.com

Authorization for Release of Information

I, _____ _____ of_____
Name Address

_____.
City State Zip
DOB_____
Hereby Authorize_____ to disclose to_____ the following specific information_____
_____
for the purpose of coordinating Medical and Psychiatric evaluation and treatment.

I have been informed of the type of information being released and that treatment is not contingent upon my decision concerning the signing of the release. I understand that I may revoke this consent at any time. This consent automatically expires in one year unless specifically stated.

Signature_____, Date_____
Client
_____, Date_____
Parent/Legal Guardian
_____, Date_____
Witness