

Authorization and Consent for Release of Information

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Client Name: _____ **Date of Birth:** _____

I hereby authorize Dr. Moller to receive, disclose or exchange information with the person/organization listed below either verbally or in writing

Parent(s)/Guardian(s): _____ **Phone:** _____

Fax: _____

Address: _____
Street City State Zip

Records Related to the Following:

Outpatient Mental Health	Case Management	Educational Reports
Inpatient Mental Health	Substance Abuse Services	Attorney Reports
Partial/Day treatment Mental Health	Child Protective Services	Police Reports
Other (specify) _____		

Information to be disclosed/received:

Intake/Admission	Progress Notes/Reports	Psychiatric Evaluations
Assessment History/Reports	Treatment Plans/Reviews	Medical History/Records
Psychological Testing/Evaluations	Discharge Summary	Medication Management
Checklists/Behavioral Observations	IEP, report cards, observations	Protective Services Narrative
Other (specify): _____		

Specific Purpose for this release of information is:

Assessment and Treatment Coordinating Care/Services Other: _____

Expiration: This consent may be revoked at any time, except to the extent that the disclosure has already occurred. If not previously revoked, this consent will expire one year from the date indicated below. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rules.

▪ I understand I have the right to inspect and receive a copy of the material to be disclosed, as required under HFS 92.05 and 92.06

This *Authorization and Consent for Release of Information* has been fully explained to me. I have been offered a copy of this form. This authorization includes treatment records accumulated after my signature through the expiration date of this consent form. I acknowledge that I am the client, or the legal representative of the client, and I agree that my drawn or generated signature is a legally binding equivalent to my handwritten signature

Client Signature: _____ **Date:** _____
(if Minor, parent or guardian signature required)