Authorization to Release Information

Patient's Name: _____

I hereby knowingly and voluntarily authorize Moving Forward, PLC to exchange treatment information with the following person (s).

Name (s) _____

Address of Person (s) _____

Phone Number (s)_____

Effective Date of Authorization ___/___/___

I understand that I must deliver written revocation to Moving Forward, PLC at 117 S. St. Asaph St., Alexandria, VA 22314, if I no longer authorize this release of information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by privacy regulations.

This authorization expires one month after the final date of treatment at Moving Forward, PLC

Printed Name: _____

Authorized Signature: _____ Date: _____

Relationship to the Patient: _____

Signature of Witness: _____ Date: _____