

Authorization to Release Information

Moving Forward, PLC

Michele T. Cole, Ph.D., LCSW, 117 S. St. Asaph St., Alexandria, VA 22314, 571-483-0306

Patient's Name

First Name Last Name

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

Name (s)

First Name Last Name

Address of Person (s)

Street Address

Street Address Line 2

City State /Province

Postal / Zip Code

Phone Number (s)

Area Code Phone Number

Effective Date of Authorization



Month Day Year

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

Signature

Date



Month Day Year

Relationship to the Patient