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Obtain Release or Exchange of Information

I hereby authorize Lu Moss Nelson, Ph.D. to ( ) obtain ( ) release or ( ) exchange records and/or oral information concerning:

( ) all records
( ) medical treatment, ___ outpatient, ___ inpatient
( ) psychotherapy, ___ outpatient, ___ inpatient
( ) family counseling
( ) school records
( ) other ____
____

Client Name ____

Date of Birth ____

Date authorized ____

Signature ____________________________________date_______________

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.