Lauren Mosback LPC
COUNSELING SERVICES

Authorization to Release Information

Client Name: _____

DOB: _____ /_____ / _____

I authorize Lauren Mosback, LPC, LBS, NCC to exchange information with:

_____

Name of Person, Organization or Institution

_____

Address

_____

Phone Number **E-mail**

The following information is authorized to be shared for 1 year:

Verbal Communication	**E-mail Communication**
Psychiatric Evaluation	**Psychological Evaluation**
Medical Record	**Academic Records**
Behavioral Report	**Other Information: _____**

I understand that to revoke this authorization, I must put a request in writing and deliver to Lauren Mosback, LPC, LBS, NCC at 1770 E. Lancaster Ave, Paoli PA. This authorization will automatically expire one year from the effective date.

Client Signature: _____ Date: _____