moxie: *The ability to face difficulty with spirit.*

EXCHANGE OF CLIENT INFORMATION

TO: _____ ☐ N/A

Name | Organization | Dates of Treatment/Service

_____

Street Address, City, State and Zip Code

_____

Telephone/Fax/Email

RE: _____

Name(s) | DOB

I authorize and request the disclosure of the information identified below for the purpose of review and evaluation in connection with professional services rendered as indicated herein. I expressly request that the designated record custodian of all entities identified above disclose full and complete information including the following:

Medical:

- ☐ Verbal consultation with the provider(s).
- ☐ All medical records, meaning every page in my record, including records received from other medical providers.
- ☐ All laboratory reports or results regarding blood, urine or breath testing for alcohol or drugs.
- ☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- ☐ All records pertaining to mental health services.
- ☐ Other:_____

Non-medical:

- ☐ Verbal consultation with the named professional(s)
- ☐ Legal Information
- ☐ School information, records, reports
- ☐ Other:_____

You are authorized to release and exchange the identified information with:

Matthew Shore, MSW, LICSW
9800 Shelard Pkwy, Suite 340
Plymouth, MN 55441

763-444-2240 (phone)
763-444-2241 (fax)
mshore@moxieinc.com

The information requested under this Authorization for Release and Exchange of Information shall be exchanged with Mr. Shore for the following purpose:

- ☐ Custody Evaluation
- ☐ Parenting Consultation
- ☐ Mediation
- ☐ Coaching
- ☐ Early Neutral Evaluation (SENE)
- ☐ Psychotherapy
- ☐ Other:_____

- In the absence of an express restriction to specific dates of treatment or service, this authorization specifically includes records prepared prior to the date of this authorization and records prepared after the date of this authorization for as long as this authorization is valid.
- I understand the information to be released or exchanged may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I authorize the release or disclosure of this type of information.
- This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records, the restrictions on which have been specifically considered and expressly waived.

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My medical treatment or payment for my medical treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein and shall be as valid as the original. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____ _____
Printed Name | Signature | Date

_____ _____ _____
Printed Name | Signature | Date