Adam Moss, PsyD

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(510) 847-8292

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the release and exchange of information between Adam Moss, PsyD and

Name or Organization Phone

Name or Organization Phone

Name or Organization Phone

Name or Organization Phone

Pertaining to the treatment of:

Name DOB

Information can be shared about myself, my child, or my family as it relates to treatment:

Unless specifically limited below, this release is for any or all information in your records. This release will remain in effect for up to two years, or for the duration of the treatment by Dr. Adam Moss, unless specifically revoked in writing prior to that time.

Limitations (if any):

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Authorized by :

Print Name	Signature	Date
Print Name	Signature	Date
Print Name	Signature	Date
Print Name	Signature	Date