PSYCHOLOGICAL AND SCHOOL SERVICES OF EASTERN CAROLINA, PLLC
KELLY C. MOYNAHAN, PhD, LPA, HSP-LPA
1025 Director Court, Suite A/1, Greenville, NC 27858

Please note: This is a legal document and will not be honored unless it is completed in full. A true and accurate photocopy for release of information shall be considered as valid as the original.

Name: ______________________________ DOB: ____________________________________

Parent/Guardian Name: __________________________

(Patient's Name or Parent/Guardian Name) I: ____
request and authorize Kelly Moynahan, PhD, HSP-LPA, dba Psychological and School Services of Eastern Carolina, PLLC to release/exchange and information over the telephone and/or through the release of records to/from the following agency, organization, or person:

To include written and verbal communication:
Place X in appropriate space
( ) release records to:
( ) receive records from:
( ) share information with:

Purpose of Disclosure:
( ) Continuity of Care
( ) Legal
( ) Request of Individual
( ) Other: ___________________________

Print Name and Address of Person/Agency/Organization:

Name: ____

Address: ____

Phone: ______________________________________ Fax: ____

I understand that the information to be released may include information regarding HIV or AIDS status, drug abuse, alcohol abuse, or psychological or psychiatric impairment.

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and therefore, may not profit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities this form informs the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing by giving the written notice or revocation to Kelly Moynahan, PhD, HSP-LPA, dba Psychological and School Services of Eastern Carolina, PLLC by delivering the written notice to 1025 Director Court, Suite A/1, Greenville, NC 27858. I understand that my revocation will not affect any actions taken by Kelly Moynahan, PhD, LPA, HSP-LPA, dba Psychological and School Services of Eastern Carolina, PLLC before receiving this notice of revocation. If not revoked earlier, this authorization expires one year from the date signed.

PATIENT'S SIGNATURE ____- - _ DATE _____________

PARENT/GUARDIAN OF PATIENT ____- - - - DATE _____________

( ) Parent ( ) Guardian ( ) Legally Responsible Person