Moxie Incorporated

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

This will authorize:

Name: _____ **and** _____

_____ Moxie Incorporated:

Org: _____ Center for Life Health, Ltd.

Address:_____ 4050 Olson Memorial Hwy, Suite 205

_____ Golden Valley, MN 55422

Phone:_____ Phone: (763) 444-2240

Fax:_____ Fax: (763) 444-2241

To Exchange Information Concerning: _____

(Name and Birthdate of Client)

The purpose of this disclosure and exchange of information is Treatment Planning and Continuing Care.

The extent or nature of the information to be discussed or exchanged is as follows:

_____ Verbal Disclosures
_____ Family and Social History
_____ Psychological and/or Psychiatric Information
_____ Progress in Treatment (i.e., chart notes)
_____ Discharge Summary, Diagnosis
_____ Psychological Testing Results, including _____
_____ Medical History, Physical Examinations and Lab Reports
_____ School records, including all transcripts, assessments, IEP, etc.
_____ Legal History, Records, etc.
_____ Other:

I understand that I may revoke this consent at any time, except to the extent that action has been taken on information released prior to the revocation of my consent. Upon the fulfillment of the above-stated purpose or the lapse of 24 months from the date of my signature, whichever comes first, this consent will automatically expire without my express revocation. I hereby release the aforementioned disclosing parties from any liability arising from these disclosures. A photocopy or facsimile of this release shall be treated in the same manner as the original.

Sign: X_____ Date: _____/_____/_____

Print Name:_____Relationship:_____

Sign: X_____ Date: _____/_____/_____

Print Name:_____Relationship:_____