Authorization to Exchange Confidential Information

I (name of client) _____ hereby authorize

(name and phone number of LMFT) _____

To exchange confidential information regarding my treatment with (name, phone number, and function of the person or entities to which information is to be exchanged) _____

_____

This authorization permits the exchange of the following information:

_____ Any and all information necessary for coordination of care

_____ Diagnosis _____ Treatment Plan

_____ Test Results _____ Dates of Treatment

_____ Summary of Treatment _____ Progress _____ Other

_____

for the purposes of evaluation and/or treatment planning.

The above information may be exchanged verbally or in writing. This authorization is given of my own free will and is in effect for one year from the date bellow. I understand that any revocation or modification of this authorization must be in writing. I may request a copy of this release.

_____ _____

name and signature of client or client's representative Date