Your Family Therapist
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Authorization to Exchange Confidential Information

I, [Name of Patient] _____

hereby authorize [Name of Provider] _____

to exchange confidential information regarding my treatment with [name and function of the person(s) or entities to which information is to be exchanged]_____

_____

This Authorization permits the exchange of the following information:

_____Any and All Information Necessary

_____Diagnosis _____ Treatment Plan _____ Prognosis

_____Progress to Date _____ Clinical Test Results _____ Dates of Treatment

_____Patient Records _____ Summary of Treatment

_____ Other _____

_____

I authorize the exchange of the information described above for the following purpose(s):

_____

_____

The recipient may use the information described above solely for the following purpose(s):

_____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or

modification of this authorization must be in writing.

This Authorization shall remain valid until: _____("Expiration Date")

By: _____Date:
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her

Representative: _____