Authorization to Exchange Confidential Information

I, [*Name of Client*] ____
hereby authorize **<u>The Counseling office of Dawn Wingert LMFT 118363</u>**
to exchange confidential information regarding my treatment with [*Name and Ph# of provider*] ____

This Authorization permits the exchange of the following information:

____ Any and All Information Necessary
____ Treatment Plan ____ Prognosis ____ Progress to Date
____ Dates of Treatment ____ Diagnosis ____ Patient Records
____ Clinical Test Results ____ 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: ________________
(Client or Client’s Representative*)

*If signed by other than Client, please indicate the relationship between Client and his/her Representative: ____________________________________