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Authorization to Exchange Confidential Information

§ I _____Date of Birth _____/_____/_____, hereby authorize

Anat Fein, LMFT, Lic#MFC 47240, to exchange confidential information with

_____	_____	_____
Name	Function	Phone number

§ This authorization permits the exchange of the following information:

¨ Any information deemed necessary for my care

Or:

¨ Diagnosis ¨ Treatment considerations ¨Treatment Plan
¨ Progress to Date ¨ Clinical Test Results ¨ Dates of Treatment
¨ Patient Records ¨ Summary of Treatment ¨ Recommendations

¨ Other: _____

§ I authorize the release of information above for the following purpose(s):

¨ Cooperation between my care providers
¨ Verification of compliance with the requirements of my (circle one):
probation officer/ court order/ employer/ other: _____

¨ Other: _____

§ I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification must be in writing.

§ This authorization is valid until: _____, or 1 year from today.

Signed by: _____ _____
Signature of patient Date

_____ _____
Signature parent/patient's representative* Date

* If signed by other than patient, indicate the relationship to patient