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Authorization to Exchange Confidential Information

I, [Name of Patient] ____

hereby authorize [Name of Provider] __Annette Mendoza-McCoy, LMFT _____

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: ____