Authorization to Release/Exchange Confidential Information

I, [Parent/Legal Guardian] ____________________ of [Name of Patient/Child] ___________________ ("Patient") hereby authorize [Name of Provider] __Julie Laraway, LMFT__ ("Provider") to release/exchange confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released] _____________________ ("Recipient").

This authorization permits the release of and exchange of the following information, with above recipient:

____ Any and All Information Necessary

____ Diagnosis ____ Prognosis ____ Treatment Plan

____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment

____ Summary of Treatment ____ Other (specify) ____

I authorize the release of and/or exchange of the above selected information for the following purpose(s):

____

____

The information to be released and/or exchanged should be used in the following ways:

____

____

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

____

____

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

The Authorization shall remain valid until: ___________________("Expiration Date") or unless otherwise revoked.

By: _______________________________ Date: ________________________

Patient or Patient's Representative

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