**Tami S. Kammer, LCPC, LMFT**

**101 Bullion St. 2 I**

**Hailey, ID 83333**

**208 578-1333**

**Authorization for the Exchange or Release of Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be Released by or Exchanged with:

Name:

Address:

I hereby authorize the exchange of educational, medical, social services and psychological information. This disclosure of information and records is required for the purposes of carrying out treatment, payment activities, and/or healthcare operations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date