Authorization to Release/Exchange Confidential Information

I, _____ ("Patient") hereby authorize Julie Laraway, LMFT ("Provider") to release/exchange confidential information obtained during the course of my treatment to [name or entities to whom information is to be released] _____ ("Recipent").

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 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) 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