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Authorization to Exchange Confidential Information

I, [Name of Patient] _________________________________ DOB_______________
hereby authorize Jacquelyn Schwartz, LMFT to exchange confidential information regarding my treatment with the following person(s) or entities to which information is to be exchanged]

Name and Title: ____
Address: ____
Telephone number: ____

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 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 one year from today's date ("Expiration Date").

(Patient or Patient's Representative*) _______________________________________

Today's Date: __________________

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative