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AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize_____to exchange confidential information with Susan Kelsey, MFT, RPT-S regarding _____
(name of client)

This Authorization permits the exchange of the following information (check one or more):

_____ 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):

_____ Collaboration on Treatment _____ Psychoeducational Information

_____ Other _____

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 will remain valid for 1 year, or until: _____

_____ _____

Date Signed Client, Parent, Guardian, or Authorized Representative

_____

Relationship (if other than client)