Susan Kelsey Weissenborn, LMFT, RPT-S
39420 Liberty St., Suite 139, Fremont, CA 94538
Phone: (800) 890-1962 Email: susankelseymft@gmail.com

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)