Authorization to Exchange Confidential Information

I, ____

hereby authorize Allison Gervais, LMFT to exchange confidential information regarding my treatment with _________________________________

phone: _________________ email: __________________________

This Authorization permits the exchange of the following information (initial):

____ Any and All Information Necessary

____ Diagnosis

____ Progress during Treatment

____ Treatment Plan ____ Prognosis _____

____ Other (please state): ____________________________________

I authorize the exchange of the information described above 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 until Date: ____________________

(If left blank, this authorization will expire one year from date of signature.)

Signature: ____________________________________ Date: __________

Printed Name: ____

*If signed by other than client, please indicate the relationship and name of client:

____