Authorization to Exchange Confidential Information

exchange confidential information regarding my treatment with [name and function of the person(s) or entities to which information is to be exchanged]	, hereby authorize, Meredith Reddoch, LMFT, to			
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 for the following purpose(s): 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 shall remain valid until: ("Expiration Date") By: Date: (Patient or Patient's Representative*)	exchange confidential information regarding my treatment with [name and function of the			
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	(Patient or Patient's	Representative*)	e:	
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	*If signed by other than Pa	atient, please indicate the relat	tionship between Patient and his/her	
Representative:	Representative:			

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