Counseling On The Alameda
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Authorization to Exchange Confidential Information

I, (Name of Client)_____

hereby authorize Debbie Hanson, MA MFT #82441 to exchange confidential information regarding my treatment with (name and function of the person(s) or entities to which information is to be exchanged)_____.

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 ____Assessments

____ 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):

_____
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_____
__

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: _____
(Client or Client's Representative*)

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