Dawn Wade, MA, ATR, CHT, LMFT

Licensed Marriage and Family Therapist
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Authorization to Exchange Confidential Information

I, _____ hereby authorize Dawn Wade, LMFT to exchange confidential information regarding my treatment with

_____

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 up to one year)

By: _____ Date:_____
(Client or Client's Representative*)

*If signed by other than Client, please indicate the relationship between Client and his/her representative.

Rev: 02/10/2016