Authorization to Exchange Confidential Information

I, (Name of Patient) _____

Hereby authorize (Name of Provider) _____

JoLee Walker, Marriage and Family Therapist
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310-426 8556

This Authorization permits the exchange of the following information:

____Any and All Information Necessary

____Diagnosis _____Treatment Plan _____Prognosis

____Progress to Date _____Clinical Test Results _____Date 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