Authorization to Exchange Confidential Information

I, (Name of Patient)____
hereby authorize
Krysten M Rudy, MFT to exchange confidential information regarding my/my child's treatment with (name and function of the person(s) or entities to which information is to be exchanged)
Name of Individual or Agency:____
Address:____
____
Phone Number:____
____

This Authorization permits the exchange of the following information:

_____ Any and All Necessary Information
_____ Diagnosis and Dates of Treatment _____ Treatment Plans _____ Medical/Lab Results
_____ Psychological/ Psychiatric Evaluation _____ Educational Records _____ Patient Records
_____ Summary of Treatment _____ Court/ Social Service Documents
_____ Other
____
______
____
____

I authorize the exchange of the information described above for the following purpose(s):
____
____
____
____

I understand that I have the right to receive a copy of the authorization. I also understand that any cancellation or modification of the authorization must be in writing.

This authorization shall remain valid until:________________________________(expiration date)

Signature:____
Date:____________________________
(Patient or Patient's Representative*)
*If signed by other than Patient, please indicate the relationship between Patient his/her
representative:____
____