ABBY WITHEE, MFT

WORKING TOWARDS HEALTH AND HAPPINESS FOR CHILDREN, ADULTS, AND FAMILIES

Authorization to Exchange Confidential Information

I, _____
hereby authorize Abby Withee, MFT to exchange confidential information regarding my treatment with:

_____

_____

_____

[name, function, address, phone, and fax 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
____ 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: _____

_____ _____
(Patient or Patient's Representative*) Date

_____ _____
Witness Date

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