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Authorization to Exchange Confidential Information

I, _____, hereby authorize

Laura A. Reames, LMFT to exchange confidential information regarding my treatment and my child's treatment with:

Name _____

Address _____

Phone _____

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: _____

Print Name: _____

Signature: _____

Date: _____