Katie Plumb
MA, LCSW (93568)
hello@katieplumb-lcsw.com
562-731-0549

Authorization to Exchange Confidential Information

I [Name of Client]_____

hereby authorize [Name of Provider] _____

to exchange confidential information regarding my treatment with [name and function of the person(s) or entities to which information is to be exchanged]:

_____

This Authorization permits exchange of the following information:

_____

_____

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 purposes:

_____

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 [Date of expiration]:

_____

By:_____Date_____
[Client or Client's Representative]

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