Authorization to Exchange Confidential Information

I, [Name of Client] _____
hereby authorize Gregory Burns, LMFT 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 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: _____

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

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