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AUTHORIZATION FOR EXHANGE OF INFORMATION

Client Name _____Birthdate _____

I, _____ authorize Janice Maurer, LMFT to disclose/exchange client's identifiable health information, as described below, with the following individual/agency:

Name: _____
Address: _____
Telephone:_____

I understand that such contact discloses the fact that the named person has received mental health services. In addition, I understand that if the individual authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations. I acknowledge that this authorization is voluntary.

This disclosure of records is required for evaluation, treatment planning, or for the following purpose: _____

It shall be limited to the following specific information:
____ Diagnosis
____ Progress Notes
____ Treatment summary including psychosocial and psychiatric history
____ Results of psychological tests and exams
____ Legal status and pertinent custodial information
____ Results of medical tests/examinations
____ Case Consultation/Collaboration

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon. This consent expires one year from the date it was signed or when the undersigned terminates counseling services, whichever is earlier, unless another date is indicated here: _____.
Date

_____ _____
Client's Signature Date

_____ _____
Signature of Parent of Guardian Date