Yvonne Miller Counseling LMFT#99234

Authorization to Exchange Confidential Information

I, [Name of Client] _____

hereby authorize Yvonne Miller, MA, 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_____ (date or upon case closure)

_____ date_____

Client/caregiver/representative*

_____ date_____

*If signed by persons other than client please indicate relationship between client and representative.