Authorization to Exchange Confidential Information

I, _____, hereby authorize Christine Livingston, LMFT to exchange confidential information regarding my 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: _____

Client Name:

Date of Birth: