****

**Authorization to Exchange Confidential Information**

I, (Patient name) (DOB)

 (address) (phone)

hereby authorize Laara Israhel, lmft #50309, to exchange confidential information regarding my treatment with:

 (name and title)

 (address)

 (phone and fax)

This Authorization permits the exchange of the following information (check all that apply):

\_\_\_\_ Any and All Information Necessary

\_\_\_\_ Diagnosis \_\_\_\_ Treatment Plan \_\_\_\_ Prognosis

\_\_\_\_ Progress to Date \_\_\_\_ Clinical Test Results \_\_\_\_ Dates of Treatment

\_\_\_\_ Patient Records \_\_\_\_ Summary of Treatment

\_\_\_\_ Other

The recipient may use the information described above solely for the following purpose(s):

 , mental health care and treatment.

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: or 1 year from today’s date.

 (patient signature or representative)

 (today’s date)

\*If signed by other than Patient, please indicate the relationship between patient and his/her representative: