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Authorization to Exchange Confidential Information

I, (Name of Client) ____DOB_________
hereby authorize Judy Moore, MFT, to exchange confidential information regarding my treatment with (Name and function of person(s)or entities to which information is to be exchanged:

____
____
____
____

This authorization permits the exchange of the following information:

__X___Diagnosis
__X___Progress to Date
__X___Client Records
_____Other____

___X__Treatment Plan
___X___Dates of Treatment
___X__Summary of Treatment

____
I authorize the exchange of the information described above for the following purpose(s): ____

Continuity of care to better serve client.
____

____

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.

____
Signature of Client or Client's Representative* Date

____

This Authorization shall remain valid for one year past the signature date. If signed by other than Client, please indicate the relationship between Client and his/her Representative: