Beliza Perdomo, M.A. Ed, M.A. LMFT
LICENSED MARRIAGE AND FAMILY THERAPIST
LMFT 101761

Authorization to Exchange Confidential Information

Date: _____

I, [Name of Patient] _____ hereby authorize: Beliza Perdomo, LMFT (MFC 101761), to exchange confidential information regarding my treatment to [name and function of the person(s) or entities to which information is to be exchanged]: 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):

_____x_____

_____

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: ("Expiration Date"): _____

Patient or Patient's Representative*: _____

Guardian if under 18 years old: _____

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