Authorization to Release/Exchange Confidential Information

I, _____, hereby authorize Stephanie A. Carson, M.S., MFT to release and/or exchange confidential information regarding my treatment with _____ _____.

This Authorization permits the exchange of the following information *(please initial 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 (please specify): _____

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: _____

By: _____ Date: _____
(Patient or Patient's Representative*)

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

Witnessed by: _____ Date: _____