Campbell Teen & Family Therapy
441 N. Central Ave. #6
Campbell, CA 95008
408-579-9806

Authorization to Exchange Confidential Information

I, [Name of Patient] _____

hereby authorize,

(Therapist Name)_____

to exchange confidential information regarding my treatment to:

Name:_____
Street:_____
City, state, zip:_____
Phone #:_____
Email address: _____

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

I authorize the exchange of the information described above for the following purpose(s):
Treatment plan and assessment.

The recipient may use the information described above solely for the following purpose(s):
treatment plan and assessment.

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*)

Representative relationship to patient:_____