AUTHORIZATION TO EXCHANGE/RELEASE/RECEIVE INFORMATION

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This authorizes ______________________________ to exchange information as specified with, release information as specified to, and/or receive information as specified from the following individuals and organizations (include names and contact information):

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Regarding: _________________________________

The information so authorized is as follows: Evaluation, Diagnostic, and Treatment Information and Records obtained in the course of psychotherapy treatment.

Other: _____________________________________

Any exceptions to the entire aforementioned include: ____

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This authorization is in effect until revoked in writing.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable State law may protect such information.

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Print Name of Authorizer

____________________________________ ______________
Signature of Authorizer Date