AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, (Name of Client) _____

Hereby authorize, Aimee Rozen, Licensed Marriage and Family Therapist,

to exchange confidential information regarding my treatment/or the treatment of my minor child with:

_____

(name of the person(s) or entities to which information is to be exchanged)

_____

Address and Phone Number

This Authorization permits the exchange of the following information:

____ Any and All Information Necessary

____ Diagnosis ____ Treatment Plan ____ Dates of Service

____ Progress to Date ____ Clinical Test Results ____ Prognosis

____ 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): _____

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")

By (Client) _____ Date: _____

_____ Date: _____

Parent(s) or Client Representative (if applicable)