RUTH KRUMBHAAR MA, MFT, CYT
PSYCHOTHERAPIST, COACH, WELLNESS

Authorization to Exchange Confidential Information

I, ___________________________ hereby authorize Ruth Krumbhaar, MFT to exchange confidential information regarding my treatment with

____.

This Authorization permits the exchange of the following information:
____ Any and All Information Necessary
____ Diagnosis
____ Progress to Date ____ Patient Records ____ Other
____ Treatment Plan ____ Prognosis
____ Clinical Test Results ____ Dates of Treatment ____ 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: ___/___/___

Name: (Client or Client's Representative – include relationship to client)
____

Date: ___/___/___

Financial District: 582 Market Street, #212
(at the Montgomery BART/Muni station)

North Beach: 1325 Columbus Ave, Upstairs
(b/t North Point St & Leavenworth St)

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