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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: ___/___/___

Please Print Name of Client or Client's Representative. (Include relationship to Client.)

_____

Date: ___/___/___