Authorization to Exchange Confidential Information

I, ____, hereby authorize
Print your full name

Triva Ponder, Licensed Marriage and Family Counselor, license number 102289 to exchange confidential information regarding my treatment with the following person, ____ who can be
Enter name of person / entity you authorize

reached at: ____.
Contact info for person or entity

I am authorizing the exchange of the following information by initialing next to the item selected:

_____ Any and all information necessary

_____ Diagnosis _____ Dates of Treatment _____ Other

_____ Progress to Date _____ Patient Records _____ Prognosis

_____ Treatment Plan _____ Clinical Test Results

If "Other" was selected, please explain:

____

____

____

I authorize the exchange of the information as indicated above for the purpose of:

____
____
____

The recipients may use the information described above solely for the following purpose:
____
____
____

I understand that I have a right to receive a copy of this authorization. I further understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid for one year from today unless another date has been entered here: ______________________________

By: ____
Print Client Name

____ ____________________
Signature (or Legal Guardian's signature) Date

____ ____________________
Triva Ponder, LMFT 102289 Date