ANXIETY THERAPY LA

AUTHORIZATION TO EXCHANGE & DISCLOSE INFORMATION

Name: _____ Birth Date: _____

I hereby authorize Michelle Massi, LMFT to request and exchange **confidential** information regarding my treatment with the following:

Name: _____

Address: _____

Phone: _____ FAX: _____

This Authorization permits the exchange of the following information:

☐ Medical ☐ Mental Health

____ Any and All Information Necessary

____ Diagnosis ____ Treatment Plan ____ Prognosis

____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment

____ Patient Records ____ Summary of Treatment/Discharge Notes

____ Other:

_____

_____

I authorize the exchange and release of the information described above 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 will expire on: ____/_____/____; or in the event of termination.

Client: _____ Date: ____/_____/____
Print name

Client: _____ _____
Signature of client/parent/guardian/conservator Relationship to client

Therapist: _____ Date: ____/_____/____
Signature

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