

ANXIETY THERAPY LA

AUTHORIZATION TO EXCHANGE & DISCLOSE INFORMATION

Name: _____ Birth Date: _____

I hereby authorize Nicholas Jewell, Licensed Clinical Psychologist (PSY 26977), 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