

ANXIETY THERAPY LA

AUTHORIZATION TO EXCHANGE & DISCLOSE INFORMATION

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I hereby authorize Maythal Eshaghian, Licensed Marriage & Family Therapist (MFT 111586), 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