Authorization to Exchange Confidential Information

Client:_____ Date:_____
Last Name First Name MI

Birth date: _____

Mailing Address:_____

Street Address:_____
Street City State Zip

I, the undersigned, hereby voluntarily authorize the exchange of information between the following providers and/or their authorized representatives of the following agencies/organizations as indicated. I understand that if the organization/agency authorized to receive the information is not a health care provider then Federal Privacy Regulations may no longer protect the released information.

○ To ○ From ◉ Ongoing Exchange

Myron Walters
315 E Cotati Ave, Suite G
Cotati, CA 94931
Tel: (415) 686-3445

○ To ○ From ◉ Ongoing Exchange

This Authorization permits the exchange of the following information:

- ☐ Any and All Information Necessary
- ☐ Diagnosis ☐ Treatment Plan ☐ Prognosis
- ☐ Progress to Date ☐ Clinical Test Results ☐ Dates of Treatment
- ☐ Patient Records ☐ Summary of Treatment
- ☐ Other_____

Limitations on this Release: _____

_____

I understand that I have a right to receive a copy of this authorization. I may revoke this consent at any time. This consent is in effect only for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Office Policies form.

By: _____ Date: _____
(Client or Client's Representative*)

*If signed by other than Client, please indicate the relationship between Client and his/her Representative: _____

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