PATRICIA ROBINSON MFT

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CALIFORNIA LICENSE MFC 45071

Authorization to Exchange Confidential Information

I, _____ authorize Patricia Robinson, MFT to exchange
Client name
confidential information regarding my treatment with

_____.
Name and title

____This authorization permits the exchange of information, as necessary to coordinate and optimize treatment:

or

____This authorization is limited to only _____

_____

I understand that I have a right to receive a copy of this authorization, if I request it. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until _____.
Date

By:_____
Patient Signature/Date

For Minors:

By:_____
Parent Signature/Date