Authorization to Exchange Confidential Information

I, [Name of Patient] ____

hereby authorize [Name of Provider] ____

to exchange confidential information regarding my treatment with:

Hope Goss, Marriage and Family Therapist
MFC# 53029
5199 East PCH, Suite 510, Long Beach, CA 90804
Phone: 1-310-896-5399 Fax: 1-562-331-0978

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

____

____

I authorize the exchange of the information described above for the following purpose(s):

____

____

The recipient may use the information described above solely 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 shall remain valid until:______________________(“Expiration Date”)

By:__________________________________ Date:________________________

(Patient or Patient’s Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her

Representative:____

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