Authorization to Exchange Protected Health Information

I, _____
hereby authorize Miriam Koenig, LMFT, LPCC to exchange confidential information regarding my treatment with

NAME:_____

TITLE: _____

PHONE NUMBER: _____

ADDRESS: _____

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: _____

By: Patient or Patient Representative* _____Date:_____

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