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## AUTHORIZATION TO EXCHANGE INFORMATION

Client's Name:

Date of Birth:

I hereby request and authorize Dr. Jessica Katzman, Licensed Psychologist, to exchange confidential information obtained during the course of my treatment with the following party:

Name: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

This request and authorization applies to:

- Participation/attendance in psychotherapy only
- Mental health and substance abuse treatment (including assessment, diagnoses, treatment, medication, discharge summary)
- Other: \_\_\_\_\_

**AUTHORIZATION:** I understand that signing this authorization is voluntary, and by signing this authorization I am amending my rights to confidentiality. I have a right to obtain a copy of this authorization. I understand that I may revoke this authorization at any time by submitting a request in writing. I understand any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider, the released information may not be protected by federal privacy regulations. This authorization will not expire unless otherwise stated. I understand that this request may result in an administrative copying fee.

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(Client Signature)

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(Date)