

Eastlake Community Counseling

Jeff Palitz, MFT

Authorization to Release/Exchange Confidential Information

I, [Name of Patient] _____

hereby authorize Jeff Palitz, MFT/Eastlake Community Counseling

to release/exchange confidential information regarding my treatment with [name and function of the person(s) or entities with which information is to be exchanged]:

Contact information of person(s)/entities with which information is to be exchanged [please include address and phone number along with any other necessary information]:

This Authorization permits the release/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):

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 someone other than Patient, please indicate the relationship between Patient and his/her Representative: _____