Dr. Irit Goldman, PsyD. MFC46437
Licensed Marriage and Family Therapist
1604 ford Ave, Suite 2-A
Modesto, CA. 95350
Tel: (209)605-9626
Fax: (209)577-3412

Authorization to Exchange Confidential Information

1. [Name of Patient]

_____

hereby authorize [Name of Provider] _____

to exchange confidential information regarding my treatment with [name and function of

the person(s) or entities to which information is to be exchanged] _____

_____

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*)

(over)