COUNSELING OFFICE OF PAUL HERSH

INDIVIDUAL & FAMILY THERAPY, A PROFESSIONAL CORPORATION

Authorization to release & exchange confidential information

I _____

Complete Client Name

hereby authorize *Paul K. Hersh, MFT 32548, Psy.D.* to release and exchange confidential information regarding my treatment with:

_____ _____

Provider's Name *Phone Number:*

_____

Address:

This authorization permits the exchange and release of the following information:

- ☐ **Any and All Information Necessary**
- ☐ Diagnosis Assessments
- ☐ Progress to Date
- ☐ Patient Records
- ☐ Treatment Plan
- ☐ Clinical Test Results
- ☐ Summary of Treatment
- ☐ Prognosis
- ☐ IEP/School
- ☐ Dates of Treatment
- ☐ Other

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

- ☐ Further evaluation, treatment or care
- ☐ Treatment planning
- ☐ Rehabilitation program or services
- ☐ Training / Education

Other: _____

I understand that I have the right to receive a copy of this authorization. I also understand the nature of the records and the implications of their release. This request is entirely voluntary and will not expire unless specifically requested. A photocopy of this authorization shall be considered valid.

X _____ Date: _____

Client Signature

X _____ _____ Date: _____

Patient's Representative *Relationship to Client*

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