Authorization to Exchange Protected Health Information

I hereby authorize Emily R. Gombos, M.A., LMFT ("Provider") to exchange protected health information regarding my treatment with the following person/entity ("Recipient"):

Name ____

Title/Position ____

Company ____

Address ____

____

Phone ____

Fax ____

E-Mail ____

This authorization permits exchange of the following information between Provider and Recipient:

____ Any and All Information Necessary

____ Dates of Treatment ____ Modalities and Frequencies of Treatment Provided

____ Progress to Date ____ Prognosis ____ Clinical Test Results

____ Diagnosis ____ Treatment Plan ____ Summary of Treatment

____ Other: ____

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

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I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective. I understand that Provider cannot condition treatment upon me signing this authorization. This authorization shall remain valid until: __________________

Printed Name: ____________________________________
(Client)

Signature: ______________________________________ Date: ______________________
(Client)

Signature: ______________________________________ Date: ______________________
(Parent/Conservator/Guardian)