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Authorization to Exchange Information

This form authorizes me to exchange written and/or verbal Protected Health Information (PHI) from my clinical record or that of the child named below with the person or agency I designate.

I authorize _____Robin Furner, MFT_____

to exchange and/or release Protected Health Information (PHI) with the following:

Name: _____

Contact Information:

_____

_____

This information is to be exchanged at my request. If there are any conditions to this exchange, I will note them here: _____

_____

This authorization will expire one year from the date this form is signed or on the date I specify here:_____.

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I may revoke this authorization by signing and dating a handwritten note to that effect at any time.

Client Name (print): _____

Client Date of Birth : _____

Parent/Guardian Name (if applicable):

_____

Signature of Client or Parent/Guardian : _____

Date:_____