PACIFIC PSYCHOTHERAPY ASSOCIATES

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AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I, _____ (hereinafter referred to as "Patient"), hereby authorize

_____(hereinafter referred to as "Therapist") to exchange confidential information and records obtained in the course of psychotherapy treatment of Patient, with:

Name: _____

Address: _____

Phone / Fax: _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Therapist has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Therapist to be effective. This Authorization permits the exchange of the following information:

☐ Any and all information necessary
☐ Diagnosis
☐ Treatment plan
☐ Dates of treatment
☐ Progress to date
☐ Summary of treatment
☐ Prognosis
☐ Records
☐ 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):
_____
Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information. This authorization shall remain valid until: _____

By: _____ Date: _____
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate relationship between Patient and his/her Representative