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Authorization to Exchange Confidential Information

I, _____ hereby authorize Erin P. Hwasta, MFC 46966
(Name of Client)

to exchange confidential information obtained during the course of 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
 Client 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)

(Signature of Client)

(Date)

(Signature of Client's Representative)

(Date)

If signed by individual other than Client, please indicate relationship between Client and his/her Representative: _____