Gina Kramer, MFT
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Authorization to Exchange Confidential Information

I, [Name of Patient] ____

hereby authorize **Gina Kramer, MFT** to exchange confidential information regarding 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 ☐ Patient Records

☐ Summary of Treatment ☐ Other

I authorize the exchange of the information described above for the following purpose(s): ____
to support collaboration of care and client's access to care.

The recipient may use the information described above solely for the following purpose(s): ____
to support collaboration of care and client's access to care.

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") ____________________________

By:____ Date: __________________________
(Patient or Patient's Representative*)

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

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