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AUTHORIZATION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

I, _____ hereby authorize **Dagmara Svetcov, LMFT (MFC 45387)** to release and exchange confidential information regarding my treatment with:

_____

This Authorization permits the exchange of the following information:

____ Any and All Information Necessary

____ Dates of Treatment	____ Treatment Plan	____ Prognosis
____ Progress to Date	____ Clinical Test Results	____ Diagnosis
____ Patient Records	____ Summary of Treatment	____ Other

I authorize the release and 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:_____

_____
Client Name (Print)

_____ _____
Client Signature Date

_____ _____
Parent / Legal Guardian Signature Date