Salt Lake Relationship Therapy
Sara Collins, MA, LMFT, CEFT
Licensed Marriage and Family Therapist
Utah 9363263-3902 and California 48339

Authorization to Exchange Confidential Information

I, [Client Name] _____ hereby authorize [Therapist Name] _____ to exchange confidential information obtained during the course of my therapy with [Name of the person or entity to whom information is to be exchanged] _____

This Authorization permits the exchange of the following information:

☐ Diagnosis ☐ Treatment Plan ☐ Progress to Date
☐ Prognosis ☐ Clinical Test Results ☐ Treatment Dates
☐ Any and All Information
☐ Other (Specify) _____

I authorize the exchange of the information described above for the following purpose(s):

_____

_____

I understand I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The authorization shall remain valid for one year or until: _____

_____ _____
Client Name and Signature Date

_____ _____
Client Name and Signature Date

_____ _____
Therapist Signature Date