Sandra Braun
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Authorization to Exchange Confidential Information

I (We) hereby authorize an exchange and/or release of clinical information between Sandra Braun, LMFT #100801 and (Name of therapist, psychiatrist, social worker, agency or other):_____
Address_____City_____State____Zip_____
Phone number _____ Email address_____

I authorize the exchange of the below indicated information for the following purpose(s):_____

__ Any and All information necessary
__ Consultation
__ Progress to Date
__ Patient Records
__ Other
__ Treatment Plan
__ Clinical Test Results
__ Summary of Treatment
__ Diagnosis

Sandra Braun, LMFT #100801, guarantees that she will observe the rules of confidentiality, regarding any information, written or verbal, that is received under this agreement. It is understood that this exchange and/or receipt of information is intended solely for the purpose of furthering treatment and that any cancellation or modification of authorization must be in writing.

This authorization shall remain valid until: _____ or for one year from the date below.

A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that I have the right to receive a copy of this document.

Print name: _____

Signature: _____Date: _____