Authorization to Exchange Confidential Information

I, (Name of Patient)_____

hereby authorize (Name of Provider): Ann J. Burke MFT, RPT

to exchange confidential information regarding my treatment with (Name & function of the person(s) or

entities to which information is to be exchanged) _____

This authorization permits the exchange of the following information:

____Diagnosis ____Treatment Plan ____Prognosis

____Progress to Date ____Dates of Treatment ____Other_____

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

Payment for services provided

Treatment Planning

The recipient may use the information described solely for the following purpose(s):

Payment for services provided

Treatment Planning

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:_____

By:_____Date:_____
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between patient & his/her

Representative:_____