PowellTherapy
Daniel C Powell | M.A., MFT, BCBA

Authorization to Exchange Confidential Information

I, [Name of Patient]

_____

hereby authorize Daniel Powell, M.A., MFT, BCBA 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):

_____

_____

_____

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:_____

(818) 746-6867
Dan@PowellTherapy.com

("Expiration Date")

By:_____
Date:_____

(Patient or Patient's Representative*)

By:_____
Date:_____

(Patient or Patient's Representative*)

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

Representative:

_____