Authorization to Exchange Confidential Information

I, ____

hereby authorize John Andonakakis, LMFT #50509 to exchange confidential information regarding my treatment with;

____
____
____

This Authorization permits the exchange of the following information:

_______ Any and All Information Necessary
_______ Diagnosis
_______ Treatment Plan
_______ Prognosis
_______ Progress to Date
_______ Dates of Treatment
_______ Patient Records
_______ Summary of Treatment
_______ Other

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

The recipient may use the information described above solely for the following purpose(s): Collaboration of Treatment

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:
The end of treatment with John Andonakakis, LMFT

By: ____Date:___________________