Heather Barcroft, M.A., LPC

Individual and Group Therapy

Authorization to Exchange Confidential Information

I, [Name of Patient] _____Date of Birth_____ hereby authorize, Heather Barcroft, LPC to exchange confidential information regarding my treatment with [name and function of the person(s) or entities to which information is to be exchanged]

Doctor: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

This Authorization permits the exchange of the following information:

____ Any and All Information Necessary

____ Diagnosis	____ Treatment Plan	____ Prognosis
____ Progress Notes	____ 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):

____ Treatment Communication	____ General Communication
____ Parent Communication	____ Other: _____

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:___*12 months from signed date*___

By: _____ Date: _____
(Patient or Legal Guardian)

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

_____

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