Kathryn J. Diangson, MA, MFT, LPCC

Individual, Couples, and Family Therapy

Authorization to Exchange Confidential Information

I, _____ hereby authorize **Kathryn J. Diangson MA, MFT, LPCC**

(name of client) (name of provider)

to exchange confidential information regarding my treatment with the following individual, agency, physician, school, psychotherapist or other professional as specified below.

Name: _____

Address: _____

Phone: _____

Information released will be limited to therapeutic treatment and will be used for

_____

_____

This written release is valid for the duration of treatment and will become void upon my termination with said provider or upon the dated noted below, whichever comes first. I understand that I have a right to receive a copy of this authorization. I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Date of termination of release: _____

Name (Client)	**Signature**	**Date**

Name (Psychotherapist)	**Signature**	**Date**

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