AUTHORIZATION TO EXCHANGE INFORMATION

Client's Name: _____

Date of Birth: _____

I hereby request and authorize Dr. Gale Dhaliwal, Licensed Psychologist, to exchange confidential information obtained during the course of my treatment with the following party:

Name: _____

Address/Phone:_____

This request and authorization applies to:

❏ Participation/attendance in psychotherapy only

❏ Mental health and substance abuse treatment (including assessment, diagnoses, treatment, medication, discharge summary)

❏ Other: _____

AUTHORIZATION: I understand that signing this authorization is voluntary, and by signing this authorization I am amending my rights to confidentiality. I have a right to obtain a copy of this authorization. I understand that I may revoke this authorization at any time by submitting a request in writing. I understand any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider, the released information may not be protected by federal privacy regulations. This authorization will not expire unless otherwise stated. I understand that this request may result in an administrative copying fee.

_____ _____

(Client Signature) (Date)