Bassi Psychological Services, Inc.

Authorization to Exchange Confidential Information

I_____, DOB_____hereby authorize_____ to exchange confidential information regarding my treatment with,

Name: _____

Address: _____

Phone Number: _____

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: _____.

Patient/Patient's Representative Signature*: _____

Date: _____

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