M.A.Y. Frog Therapy
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Authorization to Exchange Confidential Information

Date: _____

I,_____(Name of Patient) authorize Hui Reccow, LMFT to release confidential information obtained during the course of my treatment to (Name and function of the person(s) or entities to which information is to be released)
_____.

I. This Authorization permits the release of the following information:
_____ Any and All Information Necessary
_____ Diagnosis _____ Treatment Plan _____ Prognosis _____ Progress to Date
_____ Summary of Treatment _____ Dates of Treatment _____ Patient Records
_____ Other (Specify) _____.

II. This Authorization shall remain valid until: _____ ("Expiration date").

III. I authorize the release of the information described above for the following purpose(s):_____.
I understand this information will not be used for any purpose other than its intended use.

IV. The recipient may use the information described above solely for the following purpose(s):
_____
_____.

V. 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 to Hui Reccow, LMFT.

By (Print Name): _____ Date: _____
(Patient or Patient's Representative*)

Signature: _____.

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