BARBARA ROSE CHATEAUBRIAND, MA
8245 20th Avenue NE #2
Seattle, WA 98115
(206) 525-9745
Licensed Mental Health Counselor #LH00008130

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I, (Name of Patient) _____ (Date of Birth: _____) (hereinafter "Patient") hereby authorize (Name of Provider) _____ , (hereinafter "Provider") to exchange confidential information regarding my treatment with Barbara Rose Chateaubriand to:

_____

_____

_____
(Name and function of the person(s) or entities to which information is to be exchanged)

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. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 8245 20th Avenue NE #2, Seattle WA, 98115 to be effective.

This authorization shall remain valid until: _____
("Expiration Date")

Client's signature _____ Date _____