

# Patricia Robinson MFT

2500 Old Crow Canyon Road, Suite 218  
San Ramon, CA 94583  
(925) 915-0924

patricia@patriciarobinsonmft.com  
<http://patriciarobinsonmft.com>  
California License MFC 45071

## Authorization to Exchange Confidential Information

I, (Client name) \_\_\_\_\_ hereby authorize Patricia Robinson, MFT to exchange confidential information regarding my treatment with (Name and title) \_\_\_\_\_

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, if I request it. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Patient's Representative\*)

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