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Authorization to Exchange Information

This form, when completed and signed by you, authorizes me to exchange protected information from your clinical record with the person you designate.

I, _____, authorize Kara Goobic, Psy.D. to exchange information relevant to my treatment, with the following person:

Name: _____

Telephone Number: _____

Address: _____

This exchange of information is authorized for the purpose of: _____
_____.

This authorization to exchange information will remain in effect until _____, unless it is revoked in writing prior to this date.

I have the right to revoke this authorization, in writing, at any time by sending such written notification to Kara Goobic Psy.D. at the above address.

_____ _____
Signature of Patient Date