Lasting transformation.

Laura C. Strom

Trauma & Disabilities Specialist
Licensed Marriage and Family Therapist LMFT49174
Licensed Professional Clinical Counselor LPCC149
Certified Rehabilitation Counselor CRC 00113822
Registered Play Therapist RPT 3178

Authorization to Exchange Confidential Information Today's date: _______________

I, [Name of Patient] ____hereby authorize [Name of Provider] ____ to exchange confidential information regarding my treatment with Laura C. Strom, Licensed Marriage and Family Therapist (LMFT 49174).

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: ____________("Expiration Date"). Signed by ______________________________
(Patient or Patient's Representative*)

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

Authorization to Release Confidential Information Today's date: _______________

I, ______________________________________ [Name of Patient] ("Patient") hereby authorize Laura C. Strom, Licensed Marriage and Family Therapist (LMFT 49174) ("Provider") to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released]
____ ("Recipient").

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 specific uses and limitations on the types of information to be released are as follows: ______________________________

The specific uses and limitations on the use of the information by Recipient are as follows: _____________________________

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: ____________("Expiration Date"). Signed by ______________________________
(Patient or Patient's Representative*)

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

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