Caroline Grieco, M.S., MFT
Licensed Marriage & Family Therapist
MFC 44402

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AUTHORIZATION TO EXCHANGE INFORMATION

I, (Name of Client)_____hereby authorize **Caroline Grieco, M.S., MFT** to exchange confidential information regarding my treatment with:

- Name of person(s) or entities to which information is to be exchanged:_____

  _____

  Address: _____

  City: _____ State: _____ Zip Code:_____

  Phone #: _____ Fax # _____

This Authorization permits the exchange of the following information:

☐ Any & All Information Necessary

☐ Diagnosis	☐ Treatment Plan	☐ Prognosis
☐ Progress to Date	☐ Diagnostic Exam Results	☐ Discharge Summary
☐ Dates of Treatment	☐ Summary of Treatment	☐ Education/Behavioral Reports

☐ Other:_____

I authorize the exchange of the information described above for the following purposes: _____

_____

The recipient may use the information described above solely for the following purposes: _____

_____

Unless otherwise revoked, this authorization shall remain valid until: _____ (Date)
If no date is indicated, this authorization will expire in 12 months after the date of signing of this form

- I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by make a written request to Caroline Grieco, M.S., MFT
- I understand that Caroline Grieco, M.S., MFT may not condition treatment, payment, enrollment or eligibility for services on my signing of this authorization
- I understand that if I authorize the disclosure of information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal privacy regulations
- I understand that I am entitled to receive a copy of this authorization

Client's Authorized Signature: _____ Date:_____

Client's Printed Name:_____

Representative's Signature (Parent/Legal Guardian Authorized to Consent):_____

Relationship (if signed by representative): _____