LITSA BRADFORD, LMFT Lic #25703
Desert Counseling Center
71777 San Jacinto Drive, Suite 204, Rancho Mirage, CA 92270
760-218-5905 litsa@litsabradford.com

Authorization to Exchange Confidential Information

I, [Name of Patient] _____,

hereby authorize [Name of Provider] Litsa Bradford, LMFT

to exchange confidential information regarding my treatment with
[name and function of the person(s) or entities with which information is to be exchanged]:

_____

This Authorization permits the exchange of the following information:

__X__ Any and All Information Applicable/Necessary

____ Diagnosis ____ Treatment Plan ____ Prognosis

____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment

____ Patient Records ____ Summary of Treatment

____ Other _____

I authorize the exchange and use of the information described above solely for the following purpose(s): Treatment Planning and Psychotherapy

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")_____

_____
Date Signed

_____ _____
Print Patient Name or Patient's Representative* Signature of Patient or Representative

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

_____