AUTHORIZATION FOR EXCHANGE
OF CONFIDENTIAL INFORMATION

PERSONS AND AGENCIES AUTHORIZED TO EXCHANGE INFORMATION:

_____ **Stacy Harris LMFT**
P.O. Box 563
_____ Provo, UT 84603

_____ **Telephone: 530-255-4169**

_____ _____
Name of Client **Telephone Number**

_____ _____
Father's Name **Mother's Name**

Reason for Release _____

_____

_____

_____ Psycho-Social History

_____ Summary of Medical Psychiatric History for the Period: _____ to _____

_____ School Records

_____ Other _____

_____

_____ _____
Client Signature (If minor signature of parent or guardian) **Date**

_____ _____
Witness **Date**

AUTHORIZATION REMAINS IN EFFECT FOR ONE YEAR FROM THE DATE SIGNED.

The client or, if minor, his/her parent or guardian, has a right to receive a copy of this authorization. (Civil Code 55.10)