Ruth Greenberg, LMFT
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Authorization to Exchange Information

I (client name), _____, authorize Ruth Greenberg, LMFT to exchange information with:

_____
Name, title & phone #, email address

regarding mental health and other types of services being provided; the client's social and emotional functioning; and any medical issues pertaining to mental health. This exchange of information is for the purpose of treatment planning and evaluation, and the comprehensive coordination of care.
I understand that this authorization expires one year from the date it was signed, unless revoked in writing prior to its expiration date.

_____ _____ Signature of authorizing party

Date_____