Catherine A. Casey, LPC, LMFT
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Authorization for Exchange of Information

Re: _____

Date of birth: _____

I give permission for, and request, the exchange of professional information between Catherine A. Casey, LPC, LMFT, and the individuals/agencies named below. This authorization includes all information available in my clinical record, unless specifically excluded below.

Information Exchange Authorized with:

_____

_____

_____

Limitations or Exclusions of Information to be disclosed :

(Specify_____)

This authorization expires one year from this day, unless otherwise noted, and I have the right to revoke this authorization at any time.

I understand that if the person or agency that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by those regulations.

_____ _____
Signature Date