AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I (name of patient) ____hereby authorize New Life Counseling Center, PLLC therapist ____ to exchange confidential information regarding my treatment with:

(Name & Title) ____

(Address) ____

(Phone/Fax) ____

I authorize the exchange of said information for the continuity of my psychological services and care. Furthermore, I understand that I have a right to receive a copy of this authorization. And if I choose to cancel or modify this authorization, I must submit this in writing to my NLCC therapist.

Client Name (Print)________________________ Date___________ Signature____

Client Name (Print)________________________ Date___________ Signature____

NLCC therapist (Print)____________________ Date___________ Signature____

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I (name of patient) ____hereby authorize New Life Counseling Center, PLLC therapist ____ to exchange confidential information regarding my treatment with:

(Name & Title) ____

(Address) ____

(Phone/Fax) ____

I authorize the exchange of said information for the continuity of my psychological services and care. Furthermore, I understand that I have a right to receive a copy of this authorization. And if I choose to cancel or modify this authorization, I must submit this in writing to my NLCC therapist.

Client Name (Print)________________________ Date___________ Signature____

Client Name (Print)________________________ Date___________ Signature____

NLCC therapist (Print)____________________ Date___________ Signature____