



Sheena Maharaj, M.S.  
Associate Marriage Family Therapist, AMFT # 79147  
Supervised By: Brandi Garner, M.S.  
Licensed Marriage Family Therapist, LMFT, LIC # 49045  
9008 Elk Grove Blvd, Ste. 11, Elk Grove, Ca 95624  
Phone: (916) 573-0108, E-Mail: [s.maharaj.vylc@gmail.com](mailto:s.maharaj.vylc@gmail.com)  
Online: [visualizeyourlifecounseling.com](http://visualizeyourlifecounseling.com)

## Authorization to Exchange Confidential Information

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
to exchange confidential information regarding my treatment with \_\_\_\_\_

This Authorization permits the exchange of the following information:

- \_\_\_\_ Any and All Information Necessary
- \_\_\_\_ Diagnosis \_\_\_\_ Treatment Plan \_\_\_\_ Prognosis
- \_\_\_\_ Progress to Date \_\_\_\_ Clinical Test Results \_\_\_\_ Dates of Treatment
- \_\_\_\_ Patient Records \_\_\_\_ Summary of Treatment
- \_\_\_\_ Other

I authorize the exchange of the information described above for the following purpose(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The recipient may use the information described above solely for the following purpose(s):

\_\_\_\_\_  
\_\_\_\_\_

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)

By: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient or Patient's Representative\*)

\*If signed by other than Patient, please indicate the relationship between Patient and his/her representative.