Consent to Exchange Confidential Information

I authorize Dr. Lisa Schenitzki and

____

(Name of Organization/Therapist/Doctor)

____

(Street)

____

(City) (State) (Zip code)

____

(Phone) (fax)

to exchange (in written and/or verbal form) the following:

_____ History

_____ Diagnosis

_____ Treatment

_____ Dates of Treatment

_____ Other (Please specify)

____

____

This consent will be valid from the date of the consent forward unless rescinded by the patient.

Patient Name: ____

Address: ____

____

Phone: ____

Signature: ________________________________ Date: __________