# RECIPROCAL EXCHANGE OF CONFIDENTIAL INFORMATION

Client Name: _____

DOB: _____

*I hereby authorize **Anita Cooper-Marquez, LMFT** to exchange and receive information with and from:* **(Provider)**

Name of Recipient (Person or Entity): **PLACER COUNTY**

Phone Number: _____ Fax Number: _____

***The following information:***

- ☒ Entire Record
- ☐ Diagnosis
- ☐ Prognosis
- ☐ Evaluation/Biopsychosocial Assessment
- ☐ Dates of Treatment/Attendance/Participation
- ☐ Other: _____
- ☐ Treatment Plan
- ☐ Progress to Date
- ☐ Symptoms
- ☐ Clinical Test Results

***Disclosure of information is for the following purposes:***

- ☒ Evaluation
- ☒ Monitoring Progress or Participation
- ☒ Treatment Planning/Case Management
- ☐ Other: _____
- ☒ Assessing Services
- ☐ Patient/Client Request
- ☒ Billing Purposes

***By signing this authorization, I am stating I understand and/or am in agreement with the following:***

•I am voluntarily signing this authorization.
•I have been provided access to the Notice of Privacy Practices which contains further information about my rights, including but not limited to use and disclosure of my record.
•I have a right to receive a copy of this authorization, and that any cancellation or

modification of it must be done in writing.
•I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.
•Provider cannot condition treatment upon me signing this authorization.
•The health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.
•My records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for the regulations.

*Release will expire on the following date:* _____

_____

Client Signature: Date

_____

Parent, Guardian, or Authorized Representative Date

_____

Witness Signature Date