McGARVA THERAPY | Counseling Psychotherapy Consulting

AUTHORIZATION FOR EXCHANGE/RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____

Print name of client Date of birth

_____

Street Address City and State Zip Code

Authorizes exchange/release/disclosure of protected health information between

Circle one

David Jung McGarva, PhD
Licensed Marriage & Family Therapist LMFT 42154
Licensed Professional Clinical Counselor LPCC 96

and

Monica Jung McGarva, M.A.
Licensed Marriage & Family Therapist LMFT 49540

_____
Provider's Name

_____
Address

_____
Phone/Email

Any/All Necessary Information to be exchanged/released/disclosed, *or*

Diagnosis	Patient Records	Dates of Treatment
Clinical Test Results	Prognosis	Progress to Date
Treatment Plan	Summary of Treatment	

PURPOSE: Client's Request *or*

Other (specify) _____

_____

_____ _____

Client's signature (Relationship if client is under 18) Today's Date

Authorization expires _____ or no later than one year from today's date.

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