

Quest Family Therapy

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Authorization for Exchange of Information

All information exchanged during the course of our work together will be held in the strictest confidence. I will not release confidential information to anyone without your specific authorization, unless the law requires disclosure. This authorization form specifies with whom information about you may be exchanged, the nature of the information, and the purpose for which it is to be exchanged. This authorization expires thirty (30) days after you cease receiving direct services from Shawn Giammattei, Ph.D., (or on the following date _____). If you have any questions about this form or how it is used, or if you would like a copy of this authorization, please ask me.

I _____, authorize Shawn V Giammattei, Ph.D.

Client Name (please print)

to exchange confidential information with:

Name of Person or Agency (please print)

Address City/State/zip

Telephone

Description of information to be exchanged:

Purpose of exchange of information:

Signature of Client

Parent/Guardian

Date

Shawn V. Giammattei, Ph.D.

Date