Rebecca "Becky" Fogarty, M.A.
Licensed Marriage and Family Therapist, MFC# 46636
Licensed Professional Clinical Counselor, LPC# 1561
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Authorization for Exchange of Personal & Confidential Information

Client Name: _____ Date of Birth: _____

I _____ give permission to the individual(s) or organization(s) indicated below to release and exchange the following confidential information with Rebecca "Becky Fogarty", M.A., LMFT, LPCC. I understand that the information to be shared is to be used to provide and coordinate services, establish eligibility for funding of services and/or to obtain reimbursement for services. **INITIAL** each authorized item in the list(s) below:

(Initial on the information you are authorizing to be shared)

_____ Financial information required for 3rd party funding
_____ Clinical treatment records / summary reports
_____ Police, probation and/or court reports
_____ Other: _____
_____ Records relative to referral
_____ Family background and personal history
_____ School Records
_____ Other: _____

(Initial those individuals and/or agencies who are authorized to share your information)

_____ County Mental Health (specify county) _____
_____ Child & Family Services (specify county) _____
_____ Probation (specify county) _____
_____ School (specify name) _____
_____ Victim Assistance (specify county) _____
_____ District Attorney's office (specify) _____
_____ Insurance Company: _____
_____ Doctor: _____
_____ Other: _____
_____ Other: _____

I understand that in signing this authorization that I am allowing the release of the information specified above. In doing so, I am waiving the provisions of both state and federal law that protect confidentiality of mental health, physical health and substance abuse records, and all applicable privileges, including without limitation, the psychotherapist-patient privilege. (Evid. Code 1010, et seq.) I also understand that any disclosure made regarding alcohol and/or drug abuse treatment is bound by Part 2 of Title 42 of the Code of Federal Regulations except that such information may be disclosed to any law enforcement agency named by me in this release. This consent is valid immediately as of the date below. It is valid for (3) years, or until twelve (12) months after treatment has terminated, or after my written withdrawal of consent. A photocopy of this authorization shall be as valid as the original.

_____ _____
Signature of Client (or if client is a minor, signature of parent or guardian) Date