F. Michael Montgomery, LCSW, LMFT

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Therapy for the heart, mind, body and spirit in a safe and healing setting

Authorization to Exchange Confidential Information

I, _____, authorize F. Michael Montgomery and _____
(Individual, Parent or Guardian) (individual or agency, etc.)

to exchange confidential information regarding _____ obtained during the course of treatment.

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If there is another or different purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to F. Michael Montgomery at 1209 College Ave., Santa Rosa, CA 95404. I further understand that a revocation of this authorization is not effective if action has already been taken based on this authorization.

Expiration

This consent expires one year from the date signed below unless you indicate a different date: _____

I understand that my receiving treatment from F. Michael Montgomery does not depend on whether I authorize this requested authorization.

I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

F. Michael Montgomery, Witness Date