JULIA FITTON, L.M.F.T.
1910 W. SUNSET BLVD., STE 440, LOS ANGELES, CA 90026
(310) 895-4157 – JULIA@JULIAFITTON.COM

Agreement for Exchange and/or Release of Information

I (We) hereby authorize an exchange and/or release of clinical information between

Julia Fitton, L.M.F.T.

and

_____

Name of therapist, psychiatrist, social worker, agency, or other

_____

Phone number or email address

__ Any and All Information Necessary
__ Diagnosis
__ Progress to Date
__ Patient Records
__ Other _____
__ Treatment Plan
__ Clinical Test Results
__ Summary of Treatment

I authorize the exchange of information described above for the following purpose(s):

_____

Julia Fitton, L.M.F.T. guarantees that she will observe the rules of confidentiality regarding any information, written or verbal, that is received under this agreement. It is understood that this exchange and/or receipt of information is intended solely for the purpose of furthering treatment and that any cancellation or modification of authorization must be in writing.

This authorization shall remain valid until: _____ or until therapy is terminated.

A photocopy of this authorization shall be considered as effective and valid as the original and I understand that I have the right to receive a copy of this document.

_____ _____

Print name Date

_____

Signature