Holly Pedersen PhD MFT
Individual, Couple and Family Psychotherapy
www.hollypedersenMFT.com

Authorization to Exchange Information

I, _____, authorize Holly Pedersen to exchange information
Name of parent/guardian

about_____
Name of client

with _____
Name, title & phone #, email address

regarding mental health and other types of services being provided; the client's social and emotional functioning; and any medical issues pertaining to mental health. This exchange of information is for the purpose of treatment planning and evaluation, and the comprehensive coordination of care.

I understand that this authorization expires one year from the date it was signed, unless revoked in writing prior to its expiration date.

_____ _____
Signature of authorizing party Date

_____ _____
Signature of therapist Date