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 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

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