Abram Sinn LMFT

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AUTHORIZATION FOR EXCHANGE OF INFORMATION

_____ Name of Client

_____ To Exchange Information

_____ Address

_____ Address

_____ City/State/Zip Code

_____ City/State/Zip Code

I hereby Authorize Abram T. Sinn and the organization/person designated above to exchange information.

____ Verbal Discussion
____ Clinical Records
____ Psychological Testing
____ School Testing

____ Case Records
____ Case Records
____ Medical Records
____ Other (Specify) _____

The purpose of such disclose:

_____

_____

I understand that I may revoke this request in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first.

I hereby knowingly and voluntarily waive the Indiana provision that this consent expires in sixty (60) days. (Initial) Yes ____ No _____

I hereby state that I have read and fully understand the above statements as they apply to me.

_____ Service Recipient Signature/Legal Guardian

_____ Date