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AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL/MEDICAL/PSYCHOLOGICAL INFORMATION

To Whom It May Concern:

RE:______________________________

I/We hereby request and authorize Michelle M. North, LMFT to conduct reciprocal exchanges of pertinent psychological, sociological, academic, and/or medical information (including results of tests, evaluations, or examinations), to be used for clinical purposes only, contained in my son's/ daughter's file with:

______________________________	______________________________
Name	Name
____________________________	______________________________
Of (Office/Company)	Of (Office/Company)
____________________________	____________________________
Phone/Fax Number	Phone/Fax Number

This authorization will remain in effect until _____________ (date) or until it is revoked in writing or one year from this date. I also acknowledge that I have the right to a copy of this agreement if so desired.

__________________________________	______________________
Client	Date
__________________________________	______________________
Parent/Guardian	Date