Kesia Carter, LCSW

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Authorization to Release or Exchange
Confidential Information

I (Patient) _____ hereby authorize Kesia Carter, LCSW to release / exchange information regarding my treatment to / with _____ for the purpose of information about:

- ☐ Any and all information Necessary
- ☐ Diagnosis ☐ Treatment Plan ☐ Prognosis
- ☐ Progress to Date ☐ Dates of Treatment
- ☐ Summary of Treatment
- ☐ Other

_____

I authorize the release / exchange of the information described above for the following purposes: _____

This Authorization shall remain valid until: _____

Patient Signature (Guardian): _____

Date: _____