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## **Authorization to Exchange Confidential Information**

I, \_\_\_\_\_  
hereby authorize Ella Soleimany, MFT  
to exchange confidential information regarding my treatment with

\_\_\_\_\_  
\_\_\_\_\_.

This Authorization permits the exchange of the following information:

Any and All Information Necessary  
 Diagnosis  Treatment Plan  Prognosis  
 Progress to Date  Clinical Test Results  Dates of Treatment  
 Patient Records  Summary of Treatment  
 Other

I authorize the exchange of the information described above for the following purpose(s): \_\_\_\_\_.  
The recipient may use the information described above solely for the following purpose(s): \_\_\_\_\_.

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: \_\_\_\_\_

By: \_\_\_\_\_  
(Patient or Patient's Representative\*)

\*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative: \_\_\_\_\_