ELIZABETH RONA, L.M.F.T., S.E.P.
Individual Marriage and Family Therapist
Somatic Experiencing® & EMDR

Authorization to Exchange Confidential Information

I, _____ hereby authorize Elizabeth Rona, L.M.F.T. to exchange confidential information regarding my treatment with_____.

This Authorization permits the exchange of:

☐ Any and all information relevant to my treatment
☐ Only the following information:

_____

_____

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

The records authorized herein will be kept for _____ before being destroyed.

This Authorization shall remain valid until: _____ ("Expiration Date")

By: _____Date: _____
(Patient or Patient's Representative)

Relationship to patient, if other than patient: _____

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