ELIZABETH RONA L.M.F.T. S.E.P.
Licensed Individual Marriage and Family Therapist
SOMATIC EXPERIENCING® and EMDR

Authorization to Exchange Confidential Information

I, ____ hereby authorize
Your Name

____ to exchange confidential information regarding my treatment with Elizabeth Rona, L.M.F.T.

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 solely for the following purpose(s):

____

____

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")

Signature_______________________________________Date:__________________

Relationship to patient, if other than patient: ________________________________

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Edited 02/14/2022