Authorization to Exchange Information

I, ______________________________, authorize Rebecca Koski LMFT to exchange information
Name of client

with ____
Name, title

____
Phone #, contact info

regarding mental health and other types of services being provided; the client's social and emotional functioning; and any medical issues pertaining to mental health. This exchange of information is for the purpose of treatment planning and evaluation, and the comprehensive coordination of care.

I understand that this authorization expires one year from the date it was signed, unless revoked in writing prior to its expiration date.

______________________________ ____________________
Client Signature Date

______________________________ ____________________
Therapist Signature Date

12381 Wilshire Blvd. #205 | Los Angeles CA 90025 | 310-728-9955 | LMFT#88826
rebecca@rebeccakoskicounseling.com