Metro West Center For Well Being
142 Exchange Street
Millis, MA 02054
P: (508) 376-6018
F: (508) 376-6070

Authorization to Exchange Information

I _____ (Print name of authorizing party) authorize Chip Wilder, LICSW to exchange information with the below identified authorized exchange party 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.

Name of Client:

_____

Name, title, phone# or email of party with whom information can be exchanged:

_____

_____ Signature of authorizing party Date_____

_____ ___Signature of therapist Date _____