



Authorization to Exchange Information

I, _____ authorize Megan Bickford, LICSW to exchange information with
Name of Client

Name, title

Phone #, address, or email address

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.

Signature of authorizing party

Date

Signature of therapist

Date