**Brandy Vanderheiden, MA, MFT, SEP**
Somatic Experiencing Practitioner
MFT#49771

## AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I, _____ on behalf of _____
(client or parent) (self or child's name)

hereby authorize Brandy Vanderheiden to exchange confidential information regarding my treatment or child's treatment with:

| Provider Name | Role | Phone | Email |
|---|---|---|---|
| | | | |
| | | | |

Mark one:

_____ Please contact them to coordinate treatment.
_____Only contact if you need additional information.
_____They will contact you if they need additional information.

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 understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This Authorization shall remain valid until one year after the date of our last session or until revoked.

By: _____ Date: _____
(Client or Client's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative: _____

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