JoAnn Fitzpatrick, MA, MFT

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Consent for Exchange of Information

I, _____, authorize JoAnn Fitzpatrick, MA, MFT, to
Client or Parent/Guardian
exchange information regarding treatment issues regarding _____
Client(s) in treatment
with the following person(s):

Name: _____

Agency: _____

Address: _____

_____

Telephone: _____ Fax: _____

This consent for exchange of information is for the purposes of:

_____

_____

_____

I fully understand the nature and the intent of this authorization. I understand that my consent is completely voluntary, and may be withdrawn, in writing, at any time. This authorization expires following termination of therapy with Ms. Fitzpatrick.

Signature of Client and/or Parent or Legal Guardian(s):

_____ _____
Client or Parent/Legal Guardian Date

_____ _____
Client or Parent/Legal Guardian Date

Signature of Therapist

_____ _____
Therapist Date