Susan M. Pittenger, Psy.D.
675 Sierra Rose, Suite 102
Reno, Nevada 89511
(775) 432-6399 775-455-4499 (Fax)

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

PATIENT NAME:_____ Date of Birth: /_____ /_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: (Home)_____ (Cell) _____

I/We, _____ **(Client, Parent/s or Guardian/s) authorize the exchange of the following listed information between:**

_____ Name	And	Susan M. Pittenger, Psy.D. 675 Sierra Rose, Suite 102 Reno, Nevada 89511 T. (775) 432-6399 F. (775) 455-4499
_____ Address		
_____ City State Zip		
_____ Telephone/ Fax		

Information which may be exchanged (Please initial):

_____☐Psychological Evaluation/testing ☐ _____ Treatment Records

_____☐History and Physical ☐ _____ Psychiatric/Medication Records

_____☐ Psychosocial/Diagnostic Assessment _____ Discharge Summary

_____☐ Verbal communication regarding: _____

_____

_____☐ Other _____

The limitations to this authorization are: _____

The purpose of this authorization is (Please initial):

_____☐ Diagnostic clarification and treatment planning/consultation

_____☐ Other _____

_____

I understand that any electronic transmission of this information, whether by cell phone, email, or FAX machine poses a potential risk to my privacy, as these devices are not secure. I further understand that I can revoke this authorization, in writing, at any time, except to the extent that action already has been taken in reliance there upon.

The termination date of the authorization is _____ (specify date).

_____ _____

Signature of Client, Parent(s), or Guardian(s) Date