

Judy Chamberlin LCSW

Individual, couples and family counseling

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Couples Consent to Exchange Confidential Information

I authorize Judy Chamberlin LCSW AND
(therapist's name)

(Name of Organization/Provider)

(Street)

(City)

(State)

(Zip)

(Phone)

(email)

To exchange (in written and/or verbal form) the following information:

___ **History, diagnosis and treatment**

___ **Diagnosis, dates of treatment and fee**

___ **Other (please specify)** _____

This consent will be valid from the date of the consent until the final date of therapy unless rescinded by the client.

Client's name _____

Spouse/Partner _____

Address _____

Phone _____

Email _____

Client's Signature

Date

Spouse/ Partner Signature

Date