Colette de Marneffe, Ph.D.
8720 Georgia Avenue, Suite 205
Silver Spring, MD 20910
301-891-2120

Authorization to Exchange Information

This form, when completed and signed by you, authorizes me to exchange protected information from your clinical record with the person you designate.

I, ____, authorize Dr. Colette de Marneffe to exchange information related to my treatment with the following person:

Name: ____ Telephone ___________________

Address: ____

This exchange of information is authorized for the purpose of: ____________________
____.

This authorization to exchange information will remain in effect until ______________, unless it is revoked in writing prior to that date. I have the right to revoke this authorization at any time, by sending written notification to Dr. Colette de Marneffe at the above address.

Signature of Patient: ____ Date: ____________