

Colette de Marneffe, Ph.D.  
2130 Pine Street  
Philadelphia, Pennsylvania 19103  
215-645-2565

**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: \_\_\_\_\_