



Vicki F. Grove, LMFT

Licensed Marriage & Family Therapist, LMFT80445

vgrove@therapistnorthcounty.com

2385 S. Melrose Drive

Vista, CA 92081

(760) 521-2998

**AUTHORIZATION FOR EXCHANGE OF
CONFIDENTIAL/MEDICAL/PSYCHOLOGICAL INFORMATION**

To Whom It May Concern:

RE: _____

I/We hereby request and authorize Vicki F. Grove, LMFT to conduct reciprocal exchanges of pertinent psychological, sociological, academic, and/or medical information (including results of tests, evaluations, or examinations), to be used for clinical purposes only, contained in my son's/ daughter's file with:

_____ 1 _____
Name

Of (Office/Company)

Phone/Fax Number

This authorization will remain in effect until _____ (date) or until it is revoked in writing or one year from this date. I also acknowledge that I have the right to a copy of this agreement if so desired.

Client

Date

Parent/Guardian

Date