Kim Kmetz, M.S., LMFT
28632 Roadside Drive, Suite 145
Agoura Hills, CA 91301

818-801-1999
MFT#20169

AUTHORIZATION TO EXCHANGE CONFIDENTIAL CLIENT INFORMATION

Client's Name_____DOB_____

I, _____, hereby authorize Kim Kmetz, LMFT to exchange information concerning my mental health treatment with:

_____

for the purpose of:

_____

_____

This consent is subject to revocation by the undersigned at any time up to the extent that action has been taken in reliance hereon. If not revoked earlier, it shall terminate one year from the date of signing.

Signed_____Date_____