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Authorization to Exchange Confidential Information

I, [name of patient] _____

Hereby authorize [name of provider] _____

to exchange confidential information regarding my treatment with [name and function of the person(s) or entities to which information is to be exchanged] _____

_____

This authorization permits the exchange of the following information:

- ☐ Any and all information necessary
- ☐ Diagnosis
- ☐ Treatment plan
- ☐ Prognosis
- ☐ Progress to date
- ☐ Clinical test results
- ☐ Date of treatment
- ☐ Patient records
- ☐ Summary of treatment
- ☐ Other _____

I authorize the exchange of the information described above for the following purpose(s):

_____

_____

The recipient may use the information described above solely for the following purpose(s):

_____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This authorization shall remain valid until: _____ (expiration date)

By: _____ Date: _____
Patient or Patient's Representative*

*If signed by other than Patient, please indicate the relationship between Patient and his or her Representative: _____