AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, [Name of Client] _____ ("Client") hereby authorize [Name of Provider] _____ ("Provider") to exchange confidential information regarding my treatment with [name or function of the person(s) or entities to whom 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 ___Dates 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 the 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: _____
(Client or Client's Representative*)

*If signed by other that Client, please indicate the relationship between Patient and his/her Representative: _____