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Authorization to Release Confidential Information

I, [Name of Patient]________________________________ ("Patient") hereby authorize [Name of Provider] ("Provider") _______________________________ to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released] ____.

("Recipient").

This Authorization permits the release of the following information:

____ Diagnosis ____ Treatment Plan ____ Progress to Date

____ Prognosis ____ Clinical Test Results ____ Dates of Treatment

____ Any and All Information Necessary

____ Other (specify)

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

The specific uses and limitations on the types of information to be released are as follows:

____

____

The specific uses and limitations on the use of the information by Recipient are as follows:

____

____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

This authorization shall remain valid for one year or until the termination of services, whichever comes first.

Signature of Client/ Guardian: ____

Date: ____