

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 ___ 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 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/her
Representative: _____