Authorization to Release Confidential Information

I, [Name of Patient]_____

hereby authorize [Name of Provider] _____

to release confidential information obtained during the course of my treatment to [name and function of the person(s) or entities to which information is to be released] _____

_____

This Authorization permits the release 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 release 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: _____