Authorization to Release Confidential Information

I, [Name of Client]_____ 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

____ Client 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: _____
(Cliemt or Client's Representative*)

*If signed by other than Client, please indicate the relationship between Client and their Representative:

_____