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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	Function of the person(s) or entities to which information is to be released]
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Street Address	City	Zip	Phone Number
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This Authorization permits the release of the following information:

- | | | |
|--|--|---|
| <input type="checkbox"/> Any and All Information Necessary | | |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Prognosis |
| <input type="checkbox"/> Progress to Date | <input type="checkbox"/> Clinical Test Results | <input type="checkbox"/> Dates of Treatment |
| <input type="checkbox"/> Patient Records | <input type="checkbox"/> Summary of Treatment | <input type="checkbox"/> 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”)

Signature: _____ **Date:** _____
(Client or Client’s Parent or Representative*)

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