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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]

_____ _____ _____ _____
Street Address **City** **Zip** **Phone Number**

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")
If no date is specified authorization will expire 90 days following termination of services.

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: _____