Authorization to Exchange Confidential Information

I, [Name of Patient] _____ __Date of Birth_____

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:

_____