



Authorization to Exchange Confidential Information

I, [Name of Patient] _____

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: _____