



**Authorization to Release Confidential Information**

I, [Name of Patient] \_\_\_\_\_ (“Patient”)  
hereby authorize [Name of Provider] \_\_\_\_\_ (“Provider”)  
to release confidential information obtained during the course of my treatment to [name or  
function of the person(s) or entities to whom information is to be released] \_\_\_\_\_  
\_\_\_\_\_ (“Recipient”).

This Authorization permits the release of the following information:

- Diagnosis                       Treatment Plan                       Progress to Date
- Prognosis                       Clinical Test Results                       Dates of Treatment
- Any and All Information Necessary
- Other (specify) \_\_\_\_\_

I authorize the release of the information described above for the following purpose(s):  
\_\_\_\_\_  
\_\_\_\_\_

The specific uses and limitations on the types of information to be released are as follows:  
\_\_\_\_\_  
\_\_\_\_\_

The specific uses and limitations on the use of the information by Recipient are as follows:  
\_\_\_\_\_  
\_\_\_\_\_

I understand that I have a right to receive a copy of this Authorization, and that any modification  
or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: \_\_\_\_\_ (“Expiration Date”)

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Patient’s Representative)