Authorization to Release Confidential Information

I, (Name of Client) _____Date of Birth_____

Hereby authorize (Name of Provider) _____

To release confidential information obtained during the course of my treatment to (name and function of the person(s) or entities to which information is to be released) _____

_____

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

____ Client Records ____ Summary of Treatment

____ Other _____

I understand that I have a right to receive a copy of this authorization. I understand that I may revoke this consent at any time, except for the information already acted upon, and that this modification must be made in writing.

This Authorization shall remain valid until: _____("Expiration Date")

By: _____ Date: _____
Client or Client's Representative*

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

Representative: _____