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)