

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 ___ Prognosis
___ Other

I authorize the exchange of the information described above for the following purpose(s):

The recipient may use the information 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 their

Representative: _____