

# 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(s) and their Representative: \_\_\_\_\_

Please email filled form to me at [ilanawassermanlmft@gmail.com](mailto:ilanawassermanlmft@gmail.com)