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
____ Progress to Date ____ Patient Records ____ Other
____ Treatment Plan ____ Prognosis
____ Clinical Test Results ____ Dates of Treatment ____ Summary of Treatment

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

_____
_____
_____

The recipient may use the information described 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 his/her
Representative: _____