Authorization to Exchange Confidential Information

I, _____ [Name of Patient]

hereby authorize_____ [Name of Provider]

to exchange confidential information regarding my treatment with whom:

_____

_____

[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
_____Other_____

_____

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:

_____

_____