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: