

## Authorization to Release Confidential Information

I, [Name of Patient] \_\_\_\_\_ (“Patient”)  
hereby authorize [Name of Provider] \_\_\_\_\_ (“Provider”)  
to release confidential information obtained during the course of my treatment to [name or  
function of the person(s) or entities to whom information is to be  
released] \_\_\_\_\_ (“Recipient”).

This Authorization permits the release of the following information:

☐ Diagnosis      ☐ Treatment Plan      ☐ Progress to Date  
☐ Prognosis      ☐ Clinical Test Results      ☐ Dates of Treatment  
☐ Any and All Information Necessary  
☐ Other (specify) \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

The specific uses and limitations on the types of information to be released are as follows:

\_\_\_\_\_  
\_\_\_\_\_

The specific uses and limitations on the use of the information by Recipient are as follows:

\_\_\_\_\_  
\_\_\_\_\_

I understand that I have a right to receive a copy of this Authorization, and that any  
modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: \_\_\_\_\_ (“Expiration Date”)

By: \_\_\_\_\_ Date: \_\_\_\_\_ (Patient or  
Patient’s Representative)