

# Authorization to Release Confidential Information

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

This Authorization permits the release 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 release 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:  
\_\_\_\_\_