Authorization to Exchange Confidential Information

I,_____hereby authorize _____ to exchange confidential information regarding my treatment with_____

_____

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.