

# 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                       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: \_\_\_\_\_