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Authorization to Exchange Confidential Information

I, ____
(client's name)

hereby authorize: __________________________________ ______________
(name of the practitioner -1)
to exchange confidential information regarding my treatment with:

____
(name of the practitioner - 2)

This Authorization permits the exchange of the following information:
Please check all applicable choices
( ) 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: _______________
(Client or Client's Representative Signature)*

*If signed by other than Client, please indicate the relationship between Client and his/her Representative:

Representative: _____________________________________ Date:__________