PSYCHOTHERAPY STRESS-RELIEF SERVICES

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Authorization to Exchange Confidential Information

I, _____ [Name of Client] 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 ❑ Patient Records
❑ Progress to Date ❑ Prognosis
❑ Treatment Plans ❑ Clinical Test Results ❑ Summary of Treatment
❑ Dates 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: _____
[Patient or Patient's Representative*]

Date: _____

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