## Authorization to Release Confidential Information

I, [Name of Patient]	("Patient")
hereby authorize [Name of Provider]	("Provider")
to release confidential information obtained during the course of	of my treatment to Iname or
function of the person(s) or entities to whom information is to b	oe released]
	("Recipient").
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This Authorization permits the release of the following informa	uion: grass to Data
Diagnosis Treatment Plan Pro Prognosis Clinical Test Results Date	giess to Date
Any and All Information Necessary	s of freatment
Other (specify)	
Other (specify)	
I authorize the release of the information described above for	the following purpose(s):
•	
The specific uses and limitations on the types of information to	be released are as follows:
•	
The specific uses and limitations on the use of the information	by Recipient are as follows:
I understand that I have a right to receive a copy of this Autho	orization, and that any
modification or revocation of this Authorization must be in wr	iting.
industrial of 1000mion of this 12mion and 100 minutes	
The Authorization shall remain valid until:	("Expiration Date")
n	••
By: Date (Patient or Patient's Representative)	e:
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