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
____ Progress to Date
____ Patient Records
____ Other
____ Treatment Plan
____ Prognosis
____ Clinical Test Results
____ Dates of Treatment
____ Summary of Treatment

I authorize the exchange of the information described above for the following purpose of continuity of care and treatment planning.

The recipient may use the information described above solely for the following purpose of continuity of care and treatment planning.

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: ( )

By: _____

Date:
(Patient or Patient's Representative*)

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