



## PSYCHOTHERAPY STRESS-RELIEF SERVICES

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### Authorization to Release Confidential Information

I, \_\_\_\_\_ [Name of Patient] hereby authorize  
\_\_\_\_\_ [Name of Provider] to release confidential information  
obtained during the course of my treatment to [Name or function of the person(s) or  
entities to whom information is to be released] \_\_\_\_\_.

This Authorization permits the release of the following information:

- Any and All Information Necessary  
 Diagnosis      ! Treatment Plan      ! Progress to Date      ! Prognosis  
 Clinical Test Results      ! Dates of Treatment

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 Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
[Patient or Patient's Representative]