## PSYCHOTHERAPY STRESS-RELIEF SERVICES

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## Authorization to Exchange Confidential Information

I <u>,</u>	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 t	to be exchanged].
This Authorization permi	ts the exchange of the following inf	Formation:
☐ Any and All Information	on Necessary	
☐ Diagnosis	! Patient Records	
☐ Progress to Date	! Prognosis	
_	! Clinical Test Results	! Summary of Treatment
	! Other:	· · · · · · · · · · · · · · · · · · ·
The recipient may use the I understand that I have a	of the information described above information described above solely right to receive a copy of this authorization of this authorization must be	y for the following purpose(s): orization. I also understand that
This Authorization shall r	remain valid until:	
	[Expiration Date]	
By:		
	[Patient or Patient's Representati	ve*]
Date:		
D.	Patient, please indicate the relationsh	-