Healing the Mind and Spirit

Authorization to Release Confidential Information

I, _____ (the client) do hereby authorize _____(the therapist) to release confidential information obtained during the course of my treatment to _____.

This Authorization permits the release of the following information:

____ Any and All Information Necessary

____ Diagnosis ____ Treatment Plan ____ Prognosis

____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment

____ Patient Records ____ Summary of Treatment

____ Other

I authorize the release 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:_____Date:_____
(Client or Client's Representative*)

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