



**Authorization to release and exchange confidential information**

I, \_\_\_\_\_ (Name of Client)  
herby authorize \_\_\_\_\_ (therapist), \_\_\_\_\_ (license) to release and exchange  
confidential information regarding my treatment with:

Providers Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

This authorization permits the exchange and release of the following information:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Any and All Information Necessary</b> | <input type="checkbox"/> Treatment Plan        | <input type="checkbox"/> IEP/School         |
| <input type="checkbox"/> Diagnosis Assessments                    | <input type="checkbox"/> Clinical Test Results | <input type="checkbox"/> Dates of Treatment |
| <input type="checkbox"/> Progress to Date                         | <input type="checkbox"/> Summary of Treatment  |   |
| <input type="checkbox"/> Patient Records                          | <input type="checkbox"/> Prognosis             |   |
| <input type="checkbox"/> Other                                    |  |   |

I authorize the exchange and release of the information described above for the following purpose(s):

- Further evaluation, treatment or care
- Rehabilitation program or services
- Treatment planning
- Training / Education

Other: \_\_\_\_\_

I understand that I have the right to receive a copy of this authorization. I also understand the nature of the records, and the implications of their release. This request is entirely voluntary, and will not expire unless specifically requested.

X \_\_\_\_\_

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

X \_\_\_\_\_

Patients's Representative: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Date: \_\_\_\_\_