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Authorization to Release Confidential Information

I, _____hereby authorize _____to release confidential information obtained during the course of my treatment to:_____

This Authorization permits the release of the following information:

____ All psychiatric/psychotherapy records
____ Letter to _____ dated: _____
____ Verbal
____ Treatment Summary
____ Other
_____

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: _____

_____ _____

Client or Client Representative Date