Authorization to Release Confidential Information

I, [Name of Patient]_____
hereby authorize _____(therapist)
at Balance Stress Management & Therapy at 620 Wing Street, Elgin, IL 60123
to release confidential information obtained during the course of my treatment
to_____
[name and function of the person(s) or entities to which information is to be released]

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 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:_____
(Patient or Patient's Representative*)

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