

Authorization to Release Confidential Information

I, _____ hereby authorize Dena Plotkin, MFC41033 to release
[Name of Client]
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 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: _____
(Patient or Patient's Representative*)

_____ Date:

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