NORTH STATE COUNSELING

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Authorization to Exchange Confidential Information

I, [Name of Patient]_____DOB:_____

hereby authorize [Name of Provider] _____

to exchange confidential information regarding my treatment with [name and function of the person(s) or entities to which information is to be exchanged]

_____

This Authorization permits the exchange of the following information (initials):

____ Any and All Information Necessary

____ Diagnosis ____ Treatment Plan ____ Prognosis

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

____ Summary of Treatment ____ Patient Records

____ Other _____

I authorize the exchange 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. _____(initial)

This Authorization shall remain valid until: ("Expiration Date")_____

_____ _____

Client or Representative Signature Date Signed

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

Witness: _____