

# NORTH STATE FAMILY COUNSELING CENTER, INC.

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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: \_\_\_\_\_