Integrative Wellness SF

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Authorization to Exchange Confidential Information

I, [Name of Client or Parent Guardian] _____

hereby authorize [Name of Provider]_____

to exchange confidential information regarding my [child's] treatment with:

_____	_____
Name	**Function of the person(s) or entities to which information is to be released]**

_____	_____	_____	_____
Street Address	**City**	**Zip**	**Phone Number**

This Authorization permits the exchange 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 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.

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

Signature: _____ Date: _____
(Client or Client's Parent or Representative*)

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