Kenneth England Therapy

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Authorization to Release Confidential Information

I, _____ ("Patient") hereby authorize _____ ("Provider") to release confidential information of my treatment to _____ ("Recipient").

This Authorization permits the release of the following information:

____ Diagnosis ____ Treatment Plan ____ Progress to Date
____ Prognosis ____ Clinical Test Results ____ Dates of Treatment
____ Any and All Information Necessary
____ Other (specify)

I authorize the release of the information described above for the following purpose(s):

_____.

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: _____ (insert expiration date).

By: _____ Date: _____

(Patient or Patient's Representative)