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Authorization to Release Confidential Information

I, [Name of Patient] _____
("Patient") hereby authorize Jessica Gillespie, LMFT ("Provider") to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released]

_____
("Recipient").

This Authorization permits the release of the following information: (please circle)

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):

_____
_____

The specific uses and limitations on the types of information to be released are as follows:

_____
_____

The specific uses and limitations on the use of the information by Recipient are as follows:

_____
_____

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: _____ (“Expiration Date”)

By: _____

(Patient or Patient’s Representative)

Date: _____