



Saga Marriage, Family & Individual Counseling, Inc.

Authorization to Release/Exchange Confidential Information

I, [Name of Patient] _____

hereby authorize Saga Marriage, Family & Individual Counseling, Inc. to release/exchange 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]

This Authorization permits the release/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 (specify) _____

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

The specific uses and limitations on the types of information to be released/exchanged 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: _____

By: _____

Date: _____

(Patient or Patient's Representative)