ANJUS Psychotherapy Inc.

Authorization to Release Confidential Information

I, [Name of Client] _____ ("Patient")

hereby authorize [Name of Provider] _____ ("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:

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: _____ **Date**: _____

(Patient or Patient's Representative)

Name: _____

(Please Print)