Print Form

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Authorization to Exchange Confidential Information

I, _____ hereby authorize Samantha Wakach LCSW to exchange confidential information regarding my treatment with_____

This Authorization permits the exchange of the following information:

☐ Any and All Information Necessary
☐ Diagnosis
☐ Progress to Date
☐ Dates of Treatment
☐ Summary of Treatment
☐ Treatment Plan
☐ Clinical Test Results
☐ Patient Records
☐ Prognosis
☐ 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: _____

By: _____ Date: _____
(Patient or Patient's Representative*)
*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:

Authorization to Release Confidential Information

I, _____ hereby authorize Samantha Wakach LCSW to release confidential information obtained during the course of my treatment to_____.

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)