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Authorization to Release Confidential Information

I, _____("Patient")

hereby authorize Jürgen Braungardt, MFT, ("Provider") to release confidential information obtained during the course 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):

_____

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)