



**The Halverstadt Group**

647 W. Shaw Ave, Suite B  
Fresno, CA 93704  
Phone: (559) 977-4999  
www.addjohn.com

**Authorization to Release Confidential Information**

I, [Name of Patient] \_\_\_\_\_ (“Patient”) hereby authorize [Name of Provider] **The Halverstadt Group** (“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)



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