



The Halverstadt Group
 647 W. Shaw Avenue, 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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