Authorization to Release Confidential Information

I, [name] _____ ("Patient") hereby authorize Dr. Debra Ruben ("Provider") to release confidential information and records obtained during the course of my treatment to [name or function of the persons(s) or entities to whom information is to be released] _____ ("Recipient").

Such disclosure shall be limited to the following types of information *(please state limitations if necessary):*

_____

_____

Disclosure of information and records is authorized for the following purpose:

_____

_____

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)