



Authorization to Release Confidential Information

I, [Name of Client/Guardian] _____
hereby authorize Jon B. Pease, MA to release confidential information obtained
for myself child family (circle one) 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)