

Counseling and Education Services

Directions, Inc.

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Authorization to Release or Exchange Confidential Information

I, _____ hereby authorize _____
to release or exchange confidential information obtained during the course of my treat-
ment to _____.

Contact number _____ Fax number _____.

This Authorization permits the release of the following information:

_____ Any and All Information Necessary	_____ Diagnosis
_____ Treatment Plan	_____ Prognosis
_____ Progress to Date	_____ Clinical Test Results
_____ Dates of Treatment	_____ Patient Records
_____ Summary of Treatment	_____ Other

I authorize the release of the information described above for the following purpose(s):

The recipient may use the information described above solely for the following
purpose(s):

I understand that I have a right to receive a copy of this authorization. I also understand
that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: _____.

By: _____ Date: _____
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and
his/her Representative: _____