

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, [Name of Patient] _____ ("Patient")
hereby authorize [Name of Provider] _____ **MINDFUL THERAPY CENTER** _____ ("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] **KAISER PERMANENTE** ("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)