Alternative Health Consultants
A California Corporation.

Authorization to Release – Exchange Confidential Information

I, (Print Name of Client) _____ hereby authorize ***Alternative Health Consultants*** to release – exchange confidential information obtained during the course of my treatment with ***(****List name or entities to which information is to be released - exchanged):*_____

This Authorization permits the release – exchange of the following information:

☐ Any and all information necessary ☐ Treatment Plan ☐ Prognosis

☐ Diagnosis ☐ Progress to date ☐ Clinical test results

☐ Dates of Treatment ☐ Patient records ☐ Summary of treatment

☐ Other: _____
_____

I authorize the release – exchange of information described above for the following purposes:
_____
_____

The recipient may use the information described above for the following purposes: _____
_____

I understand that I have the 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 while client is in treatment, and up to one year after treatment ends. A copy is as valid as the original. I authorize that this form may be FAX'd if necessary. I authorize Alternative Health Consultants to keep my referring party updated through mailing, e-mailing, and / or Faxing updates / reports.

By: _____ Date: _____
(Client or Client's Representative)

Witnessed: _____ Date: _____
(Agency Representative)
If signed by other than Client – please indicate the relationship between Client and his / her Representative. _____

Offices located at:

5588 N. Palm Avenue, Suite K-2 Fresno CA 93704 559.289.0669 (T)
607 N. Douty Ave. Hanford CA 93230 559.582.8008 (T)