Authorization to Exchange PHI

I hereby authorize Rise Canyon Ranch ("Provider") to exchange protected health information regarding my treatment with the following person/entity ("Recipient"):

PRINTED NAME _____

TITLE / POSITION _____

COMPANY _____

PHONE NUMBER _____

ADDRESS _____

EMAIL ADDRESS _____

FAX NUMBER _____

This authorization permits exchange of the following information between Provider and Recipient:

- ☐ Any and all information necessary
- ☐ Dates of treatment
- ☐ Progress to date
- ☐ Diagnosis
- ☐ Prognosis
- ☐ Modalities and frequencies of treatment provided
- ☐ Treatment plan
- ☐ Clinical test results
- ☐ Summary of treatment
- ☐ Other: _____

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

_____

_____

I understand that I have the right to receive a copy of this authorization and that any cancellation or modification of it must be in writing. This authorization shall remain valid until: _____.

CLIENT NAME _____ **CLIENT SIGNATURE** _____ **DATE** _____

PARENT / GUARDIAN NAME (IF UNDER 18) _____ **PARENT / GUARDIAN SIGNATURE (IF UNDER 18)** _____ **DATE** _____

REPRESENTATIVE (IF NEEDED) _____ **RELATIONSHIP TO PATIENT** _____ **DATE** _____