Karie Klim, MA, LMFT

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AUTHORIZATION FOR RELEASE OR EXCHANGE OF CONFIDENTIAL INFORMATION

Date:____/____/____

I,_____, authorize Karie Klim, MFT Intern, to release and/or exchange (client) confidential case information with the following individual:

_____ / _____
(Name) (Position)

_____
(Organization) (Phone Number

_____
(Street Address)

_____
(City, State, Zip)

The information shall be limited to the following specific kinds of data:

1. Complete client chart _____
(client initials)
2. Other (be specific) _____

The purpose for the release of this information is:

____to assist client in his or her healing process_____

This authorization expires thirty (30) days after you cease receiving direct services from Karie Klim, MA, LMFT (or on the following date_____.

I am releasing this information of my own free will, and understand that I may revoke this consent at any time. I understand that I can request a copy of this form.

_____
(Name of client)

_____
(Client's signature)