Consent to Release Confidential Information

I, _____ [Name of patient] hereby authorize Karie Klim, LMFT, to release confidential information obtained during my treatment to _____ [Name or function of the person(s) or entities to whom the information is to be released.

This authorization permits the release of the following information:

❑ Any and all information necessary		❑ Diagnosis
❑ Treatment plan	❑ Progress to Date	❑ Prognosis
❑ Dates of Treatment		❑ Clinical Test Results
❑ Other (please specify)		

I authorize the release of the information 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 types of 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.

Authorization shall remain valid until: _____

_____ _____

Signature Date

_____ _____

Patient or Patient's Representative (please print) Signature of Patient or Patient's Representative

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