



## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

To: \_\_\_\_\_

Fax: \_\_\_\_\_

Message: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I authorize Kathryn de Bruin, M.F.T., MFC 43615

to release/receive information regarding:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

This authorization permits the exchange of the following information:

- |                                                            |                                                |                                       |
|------------------------------------------------------------|------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Any and all information necessary |                                                |                                       |
| <input type="checkbox"/> Diagnosis                         | <input type="checkbox"/> Treatment Plan        | <input type="checkbox"/> Prognosis    |
| <input type="checkbox"/> Client Records                    | <input type="checkbox"/> Clinical Test Results | <input type="checkbox"/> Medical Info |
| <input type="checkbox"/> Treatment Dates                   | <input type="checkbox"/> Treatment Summary     | <input type="checkbox"/> Other        |

Expiration: Six months after date below.

I understand that, upon my request, I may receive a copy of this release. I further understand the above consents can be withdrawn by me, in writing, at any time and that the information which is being disclosed if from records whose confidentiality is protected by Federal Law.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date