



Authorization to Release Confidential Information

I, [Name of Patient] _____ (“Patient”)

hereby authorize **Kate Pieper, LMFT** to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released]

_____ (“Recipient”).

This Authorization permits the release of the following information:

- Diagnosis Treatment Plan Progress to Date
- Prognosis Clinical Test Results Dates of Treatment
- Any and All Information Necessary
- Other (specify) _____

I authorize the release of the information described 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 use of the 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.

The Authorization shall remain valid until: _____ (“Expiration Date”)

By: _____ Date: _____
(Patient or Patient’s Representative)