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Authorization to Release Confidential Information

I/We, [Name of Patient/s and/or Parent/s] _____

_____ hereby authorize **Beth Kanne-Casselman MEd, MFT,License # MFC41818** to receive confidential information obtained during the course of consultation with [name and function of the person(s) or entities to which information is to be released/received]

_____. This Authorization permits the release of the following information:

____ Any and All Information Necessary
____ Diagnosis ____ Prognosis
____ Clinical Test Results ____ Patient Records
____ Treatment Plan ____ Progress to Date
____ Dates of Treatment ____ Summary of Treatment
____ Other _____

I /We authorize the release of the information described above for the following purpose(s):

_____

_____

_____

_____.

I/We understand that I/we have a right to receive a copy of this authorization. I/We also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until**:** _____ ("Expiration Date")

Patient or Patient's Representative* Signatures/:

By:_____ Date:_____

By:_____ Date:_____

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative : _____