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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, [Name of Client] _____ ("Client")

hereby authorize Kami Storck, LMFT ("Provider") 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:

____ Any and All Information Necessary

____ Diagnosis ____ Treatment Plan ____ Progress to Date

____ Prognosis ____ Clinical Test Results ____ Dates of Treatment

____ 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.

_____

_____

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

By: _____Date: _____
(Client or Client's Representative*)

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

_____ _____
Kami Storck, LMFT (therapist signature) Date