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Release Confidential Information Consent

My name is ("client") _____ and I hereby authorize ("provider") Sean Niko Kuyper, MA, LMFT to release confidential information regarding my treatment to ("recipient") _____.

This authorization permits the release of the following information:

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

I authorize the exchange of this information (detailed above) for the following purpose(s):

_____

_____

The recipient may use the information (detailed above) solely for the following purpose(s):

_____

_____

This Authorization shall remain valid until: _____

By signing this form, I verify that I am the "client" named above. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. A photocopy or facsimile of this release shall be honored as authoritative. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization.

Signature: _____ Date: _____

**Please use the back of this form to provide relevant contact information of the above named recipient.*