Brian Burns
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Woodbury, MN 55125
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Authorization to Release Confidential Information

This form authorizes the release of the client's confidential information with the following stipulations:

I (client)_____, DOB_____

and/or (parent/guardian)_____ authorize

Brian Burns, LMFT to

Exchange Information With _____ Disclose Information To _____ Obtain Information From _____

Name and/or Facility: _____

Address: _____

Phone: _____ Email: _____

For the purpose of: Treatment Coordination _____ Requested by _____
Other_____

For the dates of care/service from _____ to _____ .

I have the right to revoke this authorization, in writing at any time by sending the written notification to Brian Burns, LMFT. The revocation will be effective the date it is received. I understand that any use or disclosure of information prior to the effective date of the revocation will not be affected by the revocation.

I understand that if I choose not to sign this authorization, my refusal will not affect my ability to receive treatment from Brian Burns, LMFT, or my eligibility for benefits.

I understand that once the requested information has been disclosed to a person or entity not held to federal privacy regulations, as requested in the authorization, the recipient may no longer protect the information from re-disclosure.

I have a right to a copy of this signed authorization.

This authorization will expire on (date)_____ or one year from the date of signature.

_____ _____ _____
Client or Parent/Guardian Signature/Representative Relationship to Client Date