



*Maple Counseling Center*-----

### Authorization to Release Confidential Information

I, [Name of Patient] \_\_\_\_\_ ("Patient")  
hereby authorize] Maple Counseling Center ("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:

- 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): Case  
Managment

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)