



Release of Information

I, _____, authorize Kana Nootenboom, MS, MFT to disclose the information initialed below TO and/or FROM _____.

(Person or agency to which disclosure is to be made)

Purpose of disclosure:

_____ Diagnosis

_____ Treatment Plan

_____ Assessment

_____ Progress Notes/Intervention

_____ Discharge Summary/Status

_____ Case Management

_____ Payment

_____ Other, please specify: _____

I understand that my records are protected under federal regulations and Nevada statutes and administrative regulations and any further disclosure is prohibited without the consent of the undersigned. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance to it. I understand that this authorization will automatically expire twelve (12) months after date signed.

I further release Kana Nootenboom, MS, MFT from any liability arising from the release of information to the person/agency designated above. I acknowledge that the information to be released was fully explained to me and this consent is given of my free will.

Client Written Full Name

Date

Client Signature

Date

Kana Nootenboom, MS, MFT

Date