



**Korinne Bouwhuis, LMFT**  
 Individual, Couple and Family Therapy

KB Therapy  
 P.O. Box 957  
 Midway, Utah 84049  
 435-512-5100

**AUTHORIZATION TO RELEASE INFORMATION**

Today's Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Guardian Name (if applicable): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Client Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Client's Phone #: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Korinne Bouwhuis, LMFT  
 of KB Therapy at 230 East Deer Ridge Way, Midway, Utah 84049, to supply and/or receive information  
 about \_\_\_\_\_ to/with  
 (client name)

\_\_\_\_\_ / \_\_\_\_\_ in either verbal or  
 (other party name) (phone number)

written form. Please send any written correspondence to KB Therapy to mailing address of PO Box 957,  
 Midway Utah 84049, or to the fax number of 815-550-1287. My signature below indicates that I fully  
 consent to this transfer and sharing of information and that I release Korinne Bouwhuis, LMFT from any  
 and all liability associated with the release of this information.

Client/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_