CONSENT TO RELEASE
OF CLIENT RECORDS / INFORMATION

TO:

Name:_____

Address:_____

Telephone:_____

CLIENT:

Name:_____

Date of Birth:_____

I, the undersigned, consent to/authorize_____to release and disclose information from my medical, educational, psychiatric / drug / alcohol records – specifically :

- □ **Outpatient Therapy**
- □ **Inpatient Therapy**
- □ **Day Treatment**
- □ **Prior Treatment**
- □ Other:

For the following purpose(s):

- □ **Treatment coordination and Support**
- □ **Monitoring Progress**
- □ **Payment for Professional Services Rendered**
- □ **Other:**

Information may be released to: **Amy B. Lindholm, MS, LPC**
Portland Wellness Center
6274 SW Capitol Hwy
Portland, OR 97239
(503) 422-7050

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire 12 months after the date of client termination unless another date is specified.

Specification of the date, event or condition upon which this consent expires:

Client name_____

Signature of Client:_____ Date_____

Therapist's Signature: _____