CONSENT TO DISCLOSURE OF CLIENT RECORDS / INFORMATION

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

CLIENT:

Name:_____

Address:_____

Telephone:_____

I, the undersigned authorize Amy B. Lindholm, LPC, to release and disclose information from my medical, educational, psychiatric / drug / alcohol records – specifically :

- □ **Outpatient Therapy**
- □ Other:

For the following purpose(s):

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

Information may be released to:

Name:_____

Address:_____

Telephone:_____

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: _____