Paul Bolle, LMFT #T1687

1210 Pearl Street, Eugene, OR 97401

541.972.1305 pwb444@gmail.com

Release of Information/Authorization to Exchange Confidential Information

I, [Name of Client]

_____

hereby authorize Paul Bolle, LMFT Intern, to exchange confidential information regarding my treatment with [name of the person(s) or entities with which information is to be exchanged]:

_____

This Authorization permits the exchange of the following information:

____Diagnosis
____Progress to Date
____Client Records
____Other:_____

____Treatment Plan Dates
____of Treatment Summary
of Treatment
____

_____

I authorize the exchange of the information described above for the following purpose(s):

_____

_____

I understand that I have a right to receive a copy of this authorization if I request it. I also understand that any cancellation or modification of this authorization must be in writing.

_____

Signature of Client or Client's Representative

_____

Date

This Authorization shall remain valid for the extent of treatment.