AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby give permission to

_____

(School/Institution/Person)

Address: _____

Phone: _____

FAX: _____

TO RELEASE INFORMATION TO AND RECEIVE INFORMATION FROM:
Lynn Stoffers, L.P.C.
Mailing Address: 6501 E. Greenway Pkwy., #103-493
Scottsdale, AZ 85254
Phone: 602-354-2577
FAX: 602-675-1460

The following information:

_____ Diagnosis/Assessment
_____ Treatment Plan
_____Treatment Summaries
_____ Treatment Recommendations
_____ Expected Length of Treatment
_____Other (Specified below)

_____

_____

For the purpose of: _____
Date of this release: _____ to _____

I understand and agree that no legal responsibility or liability of any nature shall attach to the attending therapists in acting upon this authorization and request. I understand that I many revoke this authorization at any time and must do so in writing. If I do not revoke it, this consent will expire one year after my case is closed or on the date stipulated.

Client: _____ Date of Birth: _____

Signed: _____ Date: _____