Tina Bollendorf, MFT

Consent to Release Information

This release of information form authorizes information from my records (or my child's record) to be shared between Tina Bollendorf, MFT and the person or agency named below.

I give permission to Tina Bollendorf, MFT to share information with:

_____
(Name of provider or facility)

_____
(Phone number of provider or facility)

The information to be shared is to be used for the purpose of conducting reviews of evaluations, treatment plans, discharge planning, and/or for the authorization of reimbursement. I understand that any information revealed will be limited to that done so in my best interest.

I understand that this authorization is valid for six months from the date listed below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

Name: _____ Date: _____
please print

Signature: _____

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