



A Team Of Independent Practitioners Providing Psychological, Educational & Organizational Services

Release of Information

I, _____ authorize
(CLIENT NAME AND DOB)

(NAME/AGENCY)

(ADDRESS/PHONE/FAX)

to exchange release receive information from my records with:

Susan Reuling Furness, M.Ed., LCPC, LMFT

Jefferson Street Counseling & Consulting

1517 W. Jefferson • Boise, Idaho 83702 • 208-385-0888

This release is authorized for the purpose of:

Counseling and therapy (treatment coordination and planning)

Other _____

Any information gained or released will be used in compliance with the client.

This release is in accordance with Federal Confidentiality Regulations as expressly defined in Part 2 of Title 42. It can be revoked at any time and will expire at such a time as authorized under these regulations.

Client's Signature: _____

Date: _____

Witness' Signature: _____

Date: _____