George T. Lynn, M.P.A., M.A., L.M.H.C., L.P.C.
Mailing: 1292 High Street, Box 1095, Eugene, Oregon, 97401
Phone: (541) 315-3185 Email: georgelynn@comcast.net
Fax: (425) 533-2312

Authorization for Release of Records and Information

I_____(name of client) hereby give permission to George Lynn, M.A. to disclose to/receive from_____information pertaining to my treatment in counseling conveyed by paper or electronic media to include relevant records.

I may revoke this consent at any time. If I do not revoke it, this consent will expire upon termination of treatment.

_____
Signature of client or parent of client (if client is under the age of 13)

_____
Date