



## Release of Information

I, \_\_\_\_\_  
(name)

\_\_\_\_\_  
(address)

authorize

\_\_\_\_\_  
(name/agency)

\_\_\_\_\_  
(address)

to  exchange  release  receive information from my records with:

**Timothy J. 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: \_\_\_\_\_