



Karen DeBolt
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Please call for fax number

INFORMATION RELEASE AUTHORIZATION

I HEREBY AUTHORIZE _____
(Name of person/facility providing information)

(Address)

- TO RELEASE INFORMATION CONCERNING _____
- TO RECEIVE INFORMATION CONCERNING _____

TO Karen DeBolt, MA, ADHD Advantage, 5234 NE Farmcrest St., Hillsboro, OR 97124

I HEREBY ACKNOWLEDGE THAT THIS CONSENT IS VOLUNTARY AND WILL EXPIRE AUTOMATICALLY AFTER 365 DAYS FROM THE DATE ON WHICH IT IS SIGNED. I FURTHER ACKNOWLEDGE THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION BASED ON THIS CONSENT HAD BEEN TAKEN.

NAME: _____ DATE: _____

ADDRESS: _____

SIGNATURE: _____ WITNESS: _____